Ontario

SCHEDULE OF BENEFITS
April 1, 2007
AMENDMENT LIST INSTRUCTION SHEET

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IF ANY PAGES ARE MISSING CONTACT: YOUR LOCAL MINISTRY OF HEALTH AND LONG-TERM CARE OFFICE

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HYPNOTHERAPY

Definition:

Hypnotherapy is a form of treatment that has the same goals as psychotherapy but is rendered with the patient under hypnosis.

Payment rule:

Hypnotherapy is *not eligible for payment* when rendered on the same day to the same patient by the same physician as obstetrical delivery.

COUNSELLING

Definition/Required elements of service:

Counselling is a patient visit dedicated solely to an educational dialogue with a physician. This service is rendered for the purpose of developing awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and to provide advice and information in respect of diagnosis, treatment, health maintenance and prevention.

> **[Commentary:**
>
> 1. Advice given to a patient that would ordinarily constitute part of a consultation, assessment, or other treatment, is included as a common or constituent element of the other service, and does not constitute counselling.
> 2. Detention time may be payable following a consultation or assessment when a physician is required to spend considerable extra time in treatment or monitoring of the patient. See GP25 for further information.]

Payment rules:

1. With the exception of the codes listed in the table below, no other services are eligible for payment when rendered by the same physician the same day as any type of counselling service.

E080 G010 G202 G205 G365 G372 G384 G385 G394 G462 G480 G482
G489 G538 G590 H313 K002 K003 K008 K014 K015 K031 K035 K036
K038

2. Individual and group counselling services are limited to 3 units per patient per physician per year at the higher fee (K013 or K040 respectively); the amount payable for services rendered in excess of this limit will be adjusted to a lesser fee (K033 or K041 respectively).
3. If the patient does not have a pre-booked appointment, the amount payable for this service will be adjusted to a lesser assessment fee.

A. Individual Counselling

Definition:

Individual counselling is counselling rendered to a single patient.

B. Group Counselling

Definition:

Group Counselling is counselling rendered to two or more patients with a similar medical condition or situation.

Payment rule:

In addition to meeting the usual medical record requirements for the service, the physician must also maintain a separate record (independent of the patient's medical record) of the names and health numbers of all persons in attendance at each group counselling session or the service is *not eligible for payment*.

Claims submission instruction:

The claim must be submitted under the health number of the group member for whom, when the service was rendered, the largest number of counselling units had previously been claimed by the physician during the year in which the service is rendered.

C. Transplant Counselling

Definition/Required elements of service:

Transplant counselling is payable in circumstances where transplant or donation is imminent, for the purpose of providing the recipient, donor or family member with adequate information and clinical data to enable that person to make an informed decision regarding organ transplantation.

Claims submission instruction:

The claim must be submitted under the health number of the recipient or donor.

D. Counselling of Relatives on Behalf of a Catastrophically or Terminally Ill Patient

Definition:

Counselling of relatives on behalf of a catastrophically or terminally ill patient is counselling rendered to a relative or relatives or representative of a catastrophically or terminally ill patient, for the purpose of developing an awareness of modalities for treatment of the patient and/or his or her prognosis.

Claims submission instruction:

The claim must be submitted under the health number of the patient who is catastrophically or terminally ill.

E. Rehabilitation Counselling

Definition:

Rehabilitation counselling is counselling rendered for the purpose of developing an awareness of the modalities for treatment of the patient and/or his or her prognosis.

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

Basic Units: The number of basic units is the number of basic units listed opposite the service in the column headed with "Anae" except:

a. where multiple or bilateral surgical procedures are performed during the same anaesthetic, the number of basic units listed in the column headed with "Anae" opposite the service that describes the major procedure;

or

b. where the basic units are listed as IC, or where no basic units are listed, the amount payable is calculated by adding the appropriate time units to the basic units listed for a comparable procedure (taking into account the region, modifying conditions, or techniques).

Time Units: Time units are calculated on the basis of time spent by the anaesthesiologist and commence when the anaesthesiologist is first in attendance with the patient in the OR for the purpose of initiating anaesthesia and end when the anaesthesiologist is no longer in attendance (when the patient may safely be placed under customary post-operative supervision). Time units are calculated for each 15 minutes or part thereof. The unit value of each 15 minute period or part thereof is:

During the first hour or less	1 unit
After the first hour up to and including the second hour	2 units
After the second hour	3 units

Claims submission instruction:

Submit claims for anaesthesia services rendered with a surgical procedure using the suffix "C", with the procedural code.

[Commentary:
see Appendix H for a table stating the duration of the anaesthesia service and corresponding time units.]

AFTER HOURS PREMIUMS

These premiums are payable when a case commences:

E400C	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays - increase the total anaesthetic fee by	50%
E401C	Nights (00:00h – 07:00h) - increase the total anaesthetic fee by	75%

SPECIAL VISIT PREMIUMS

These special visit premiums are payable only for the first patient seen on each special visit (regardless of how many patients are seen during the same visit to the hospital).

Anaesthesia special visit premiums are payable when an anaesthesiologist is required to make a special visit to the hospital to administer an anaesthetic for a case that commences:

C998C	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays or for non-elective surgery with sacrifice of office hours	54.55
C999C	Nights (00:00h – 07:00h)	81.85

[Commentary:

1. The specific requirements for special visits are found in pages GP44 to GP49.
2. These premiums are payable in addition to the E400 and E401 premiums.]

CANCELLED SURGERY - ANAESTHESIA SERVICES

Payment rules:

1. If an anaesthesiologist examines a patient prior to surgery and the surgery is cancelled prior to the induction of anaesthesia, the service rendered constitutes a hospital subsequent visit.
2. When an anaesthetic has begun but the operation is cancelled prior to commencement of surgery, the service constitutes E006C with the actual number of time units added to 6 basic units for this service.

> **[Commentary**:
> If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee.]

SECOND ANAESTHESIOLOGIST

Unless otherwise specified in the *Schedule*, when the anaesthetic services of more than one anaesthesiologist are necessary in the interest of the patient, the service provided by the second anaesthesiologist constitutes E001C with the actual number of time units (based on the actual time assisting the first anaesthesiologist) added to 6 basic units.

REPLACEMENT ANAESTHESIOLOGIST

When one anaesthesiologist starts a procedure and is replaced by another anaesthesiologist during a surgical procedure or delivery:

a. the amount payable to the first anaesthesiologist is calculated by adding the listed procedural basic units plus time units for the time the first anaesthesiologist is in attendance.

b. except in the case of continuous conduction anaesthesia, the service provided by the replacement anaesthesiologist constitutes E005C based on the actual number of time units and no basic units. E005C qualifies for the premiums E400C or E401C only if the case commences after hours (see GP55). Each anaesthesiologist should state on his/her claim card which part of the anaesthetic is being claimed including his/her starting and finishing times.

> **[Commentary**:
> 1. Each anaesthesiologist must indicate, as part of the medical record, his/her starting and finishing times.
> 2. For continuous conduction anaesthesia, the replacement anaesthesiologist submits claims using the applicable continuous conduction anaesthesia fee code.]

OBSTETRICS – CONTINUOUS CONDUCTION ANAESTHESIA

P014C, introduction of a catheter for anaesthesia, including the first dose, has a value of 6 basic units.

P015C time units for maintenance and/or supervision are calculated on the basis of 1 unit for each ½ hour of time to a maximum of 6 units.

P016C time units for maintenance of obstetrical epidural anaesthesia are calculated on the basis of 1 unit for each ½ hour of time to a maximum of 12 units.

> **Note**:
> P015 is *not eligible for payment* when rendered the same day to the same patient as P016.

SUPPORTIVE CARE/MONITORING BY SURGICAL ASSISTANT OR ANAESTHESIOLOGIST

SPECIFIC ELEMENTS

In addition to the common elements, supportive care or monitoring by the surgical assistant or anaesthesiologist includes the following specific elements.

A. Being in constant attendance at a surgical procedure for the sole purpose of monitoring the condition of the patient (including appropriate physical examination and inquiry) and being immediately available to provide, and including the provision of, special supportive care to the patient.

B. Discussion with, and providing advice and information, including prescribing therapy to the patient or the patient's representative(s), whether by telephone or otherwise, on matters related to:

1. the service;

   and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

C. Providing premises, equipment, supplies, and personnel for any aspect(s) of the specific elements of the service that is(are) performed at a place other than the place in which the attendance occurs.

While no occasion may arise for performing element B, when performed in connection with the other elements it is included in the service.

CALCULATION OF FEE PAYABLE

The fee for this service is calculated in the same manner as for assistant and anaesthesia services.

		Asst	Anae
E003	Supportive care/Monitoring	5	6

Note:

1. For E003B, the assistants' premiums apply as for assistants' services.
2. For E003C, the anaesthesiologists' premiums apply as for anaesthesiologists' services.

INTENSIVE OR CORONARY CARE UNIT PREMIUM

C101	For each patient seen on a visit to ICU or CCU (subject to the exceptions set out below)	add	8.65

Payment rule:

C101 is *not eligible for payment* with Supportive Care or with Critical Care, Ventilatory Care, Comprehensive Care, or Neonatal Intensive Care where team fees are claimed.

> **[Commentary:**
> C101 is payable when no other separate fee is payable for the service provided in the ICU or CCU (e.g. post-operative care by surgeon).]

AFTER HOURS PROCEDURE PREMIUMS

These premiums are payable only when the following criteria are met:

a. the service provided is one of the following:

Non-elective Surgical Procedures (including fractures or dislocations), Obstetrical Deliveries, Clinical Procedures Associated with Diagnostic Radiological Examinations, Ground Ambulance Transfer (K101), Air Ambulance Transfer (K111), Transport of Donor Organs (K102), Return Trip (K112), or one of the following Major Invasive Procedures:

G082	G083	G085	G090	G091	G092	G099	G117	G118	G119	G125	G176
G177	G178	G179	G211	G246	G249	G261	G262	G263	G268	G269	G275
G277	G280	G282	G288	G294	G295	G297	G298	G303	G304	G309	G323
G324	G330	G331	G336	G347	G348	G349	G356	G380	G509	J001 to J068	

and;

b. the procedure is either (a) non-elective; or (b) an elective procedure which, because of an intervening surgical emergency procedure(s) was delayed and commenced between:

E409	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s) by	50%
E410	Nights (00:00h – 07:00h) - increase the procedural fee(s) by	75%

Payment rules:

1. E409/E410 is not payable in addition to the obstetrical fee(s) if labour is induced by medical and/or surgical means by the same physician, unless the reason for the induction is fetal distress, diabetes, premature rupture of membrane, severe pre-eclampsia, hypertension, abruption, or post-dates pregnancy. For the purpose of this provision, a forewater ARM or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.
2. E409/E410 is not payable for a procedure rendered by a physician rendering services in an emergency department who at the time the service was rendered would have been required to submit claims using "H" prefix emergency services (see GP35 of the General Preamble).

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OHIP LISTED SPECIALTIES

NOT ALLOCATED

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

General/Family Physician Emergency Department Assessment

General/Family Physician Emergency Department Assessment is an assessment of a patient that satisfies as a minimum the requirements of an intermediate assessment and is rendered by the patient's general/family physician in an emergency department funded under an Emergency Department Alternative Funding Agreement (ED AFA). For that visit, the service includes any re-assessment of the patient by the general/family physician in the emergency department and any appropriate collaboration with the emergency department physician.

The service is only eligible for payment when the general/family physician's attendance is required because of the complexity, obscurity or seriousness of the patient's condition.

A100	General/Family Physician Emergency Department Assessment	76.90

Payment rule:
No other service (including special visit or other premiums) rendered by the same physician to the same patient during the same visit to the emergency department is eligible for payment with this service.

Claims submission instruction:
For claims payment purposes, the hospital master number associated with the emergency department must be submitted on the claim.

[Commentary:

1. Services described as A100 rendered in an emergency department not funded under an ED AFA may be payable under other existing fee schedule codes.
2. In the event the patient is subsequently admitted to hospital, and the general/family physician remains the MRP for the patient, the General/Family Physician Emergency Department Assessment constitutes the admission assessment. See General Preamble GP29 for additional information.]

Certification of death

Certification of death is payable to the physician who personally completes the death certificate on a patient who has been pronounced dead by another physician, medical resident or other authorized health professional. Claims submitted for this service must include the diagnostic code for the underlying cause of death as recorded on the death certificate. The service may include any counselling of relatives that is rendered at the same visit. Certification of death rendered in conjunction with A902 or A777/C777 is an insured service payable at nil.

A771	Certification of death	17.75
A777	Intermediate assessment - Pronouncement of death (see General Preamble GP23)	31.45
A007	Intermediate assessment or well baby care	31.45
A001	Minor assessment	17.75

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Mini assessment

A mini assessment is rendered when an assessment of a patient for an unrelated non-WSIB problem is performed during the same visit as an assessment of a WSIB related problem for which only a minor assessment was rendered.

A008	Mini assessment		10.25

Annual health examination

K017	- child after second birthday*		30.40

Note:

*For Annual Adult/Adolescent health examinations - see General Preamble GP18.

Periodic Oculo-visual Assessment

See General Preamble GP24 for definitions and conditions

A110	- aged 19 years and below		40.15
A112	- aged 65 years and above		40.15

Identification of patient for a Major Eye Examination

Identification of patient for a Major Eye Examination, is the service of determining that a patient aged 20 to 64 inclusive has a medical condition (other than diabetes mellitus, glaucoma, cataract, retinal disease, amblyopia, visual field defects, corneal disease or strabismus) requiring a major eye examination and providing such a patient with a completed requisition.

E077	- identification of patient for a Major Eye Examination	add	10.25

Note:

1. This service is limited to a maximum of one every four fiscal years by the same physician for the same patient unless the patient seeks a major eye examination from an optometrist or general practitioner other than the one to whom the original requisition was provided.
2. This service is limited to a maximum of one per fiscal year by any physician to the same patient.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C005	Consultation	56.10
C905	Limited consultation	49.60
C945	Special palliative care consultation - subject to the same conditions as A945	127.50
C006	Repeat consultation	42.35
C003	General assessment	61.00
C813	Midwife-Requested Assessment - subject to the same conditions as A813	81.60
C815	Midwife-Requested Special Assessment - subject to the same conditions as A815	127.50
C004	General re-assessment	30.70
C903	Pre-dental/pre-operative general assessment (maximum of 2 per 12-month period)	61.00
C933	On-call admission assessment - subject to the same conditions as A933	79.20
C777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777	31.45
C771	Certification of death - subject to the same conditions as A771	17.75

Subsequent visits

C002	- first five weeks	per visit	29.20
C007	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C009	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP31)	per visit	29.20
C008	Concurrent care	per visit	29.20
C010	Supportive care	per visit	17.75
C882	Palliative care (see General Preamble GP35)	per visit	29.20

Attendance at maternal delivery for care of high risk baby(ies)

Attendance at maternal delivery for high risk baby(ies) requires constant attendance at the delivery of a baby expected to be at risk by a physician who is not a paediatrician, and includes an assessment of the newborn.

H007	Attendance at maternal delivery for care of high risk baby(ies)		61.65

Payment rule:

This service is not eligible for payment if any other service is rendered by the same physician at the time of the delivery.

H001	Newborn care in hospital and/or home		52.20
	Low birth weight baby care (uncomplicated)		
H002	- initial visit (per baby)		32.75
H003	- subsequent visit	per visit	16.25

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W105	Consultation	56.10
W106	Repeat consultation	42.35
	Admission assessment	
W102	- Type 1	61.00
W104	- Type 2	17.75
W107	- Type 3	30.70
W109	Annual physical examination	61.00
W777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777	31.45
W771	Certification of death - subject to same conditions as A771	17.75
W004	General re-assessment of patient in nursing home (per the *Nursing Homes Act*)	17.75

Note:
W004 may be claimed 6 months after Annual Health Examination (per the *Nursing Homes Act*).

W903	Pre-dental/pre-operative general assessment (maximum of 2 per 12-month period)	61.00
A777	Intermediate assessment - Pronouncement of death (see General Preamble GP23)	31.45

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Subsequent visits (see General Preamble GP34)

	Chronic care or convalescent hospital		
W002	- first 4 subsequent visits per patient per month	per visit	29.20
W001	- additional subsequent visits (maximum 4 per patient per month)	per visit	13.40
W882	- palliative care (see General Preamble GP35)	per visit	29.20
	Nursing home or home for the aged		
W003	- first 2 subsequent visits per patient per month	per visit	22.55
W008	- additional subsequent visits (maximum 2 per patient per month)	per visit	13.40
W872	- palliative care (see General Preamble GP35)	per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55
	Monthly Management of a Nursing Home or Home for the Aged Patient		
W010	Monthly management fee (per patient per month) (see General Preamble GP66 to GP67)		85.70

Primary mental health care

Primary mental health care is not to be billed in conjunction with other consultations and visits rendered by a physician during the same patient visit unless there are clearly different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP6, GP36 to GP40 for definitions and time-keeping requirements.

K005	Individual care	per unit	51.70

Counselling

Unit means ½ hour or major part thereof - see General Preamble GP6, GP36 to GP40 for definitions and time-keeping requirements.

	Individual care		
K013	- first three units of K013 and K040 combined per patient per provider per 12-month period	per unit	51.70
K033	- additional units per patient per provider per 12-month period	per unit	31.45
	Group counselling - 2 or more persons		
K040	- where no group members have received more than 3 units of any counselling paid under codes K013 and K040 combined per provider per 12-month period	per unit	51.70
K041	- additional units where any group member has received 3 or more units of any counselling paid under codes K013 and K040 combined per provider per 12-month period	per unit	31.45
K014	Counselling for transplant recipients, donors or families of recipients and donors - 1 or more persons	per unit	51.70
K015	Counselling of relatives - on behalf of catastrophically or terminally ill patient - 1 or more persons	per unit	51.70

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Psychotherapy

Includes narcoanalysis or psychoanalysis or treatment of sexual dysfunction - see General Preamble GP36.

Note:
Psychotherapy outside hospital and hypnotherapy may not be claimed as such when provided in conjunction with a consultation or other assessments rendered by a physician during the same patient visit unless there are clearly defined different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP6, GP36 to GP40 for definitions and time-keeping requirements.

K007	Individual care	per unit	51.70
	Group - per member - first 12 units per day		
K019	- 2 people	per unit	25.85
K020	- 3 people	per unit	17.25
K012	- 4 people	per unit	13.00
K024	- 5 people	per unit	10.70
K025	- 6 to 12 people	per unit	9.10
K010	- additional units per member (maximum 6 units per patient per day)	per unit	8.20
	Family		
K004	- 2 or more family members in attendance at the same time	per unit	56.10

Hypnotherapy

Unit means ½ hour or major part thereof - see General Preamble GP6, GP36 to GP40 for definitions and time-keeping requirements.

K006	Individual care*	per unit	51.70
K011	Group - for induction and training for hypnosis (maximum 8 people) - per member	per unit	9.10

Note:
* May not be claimed in conjunction with delivery as the service is included in the obstetrical fees.

Diabetic Management Assessment (DMA)

DMA is an all-inclusive service payable to the most responsible physician for providing continuing management and support of a diabetic patient. The service must include either an intermediate assessment or partial assessment focusing on diabetic target organ systems, relevant counselling and maintenance of a diabetic flow sheet retained on the patient's permanent medical record. The flow sheet must track lipids, cholesterol, Hgb A1C, urinalysis, blood pressure, fundal examination, peripheral vascular examination, weight and body mass index (BMI) and medication dosage. When DMA is rendered to the same patient same day as any other consultation or visit by the same physician or the above record is not maintained, the DMA is an insured service payable at nil. Maximum 3 per patient per year.

K030	Diabetic Management Assessment	36.50

Sexual assault examination

For investigation of alleged sexual assault and documentation using the evidence kit provided by Ministries of the Attorney General and the Solicitor General

K018	- female	308.70
K021	- male	243.50

Ontario Hepatitis C Assistance Program (OHCAP)

Certification of Medical Eligibility for OHCAP - includes any combination of common and specific elements of any insured service listed under "Family Practice & Practice In General" in the "Consultations and Visits" section and completion of the *Application for OHCAP - Physician's Form*. When a physician submits a claim for rendering any other consultation or visit on the same day for which the physician submits a claim for Certification of Medical Eligibility for OHCAP, the Certification service is included (in addition to the common elements) as a specific element of the other service.

K026	Certification of Medical Eligibility for OHCAP	54.70
K027	Certification of Medical Eligibility for OHCAP - includes only completion of Application for OHCAP - Physician's Form without an associated consultation or visit on the same day	21.85

Health Protection and Promotion Act - Physician Report

K031	Completion of Physician Report in accordance with Section 22.1 of the *Health Protection and Promotion Act*	102.50

Specific neurocognitive assessment

A specific neurocognitive assessment is an assessment of neurocognitive function rendered personally by the physician where all of the following requirements are met:

a. test of memory, attention, language, visuospatial function and executive function

b. a minimum of 20 minutes (consecutive or non-consecutive) and must be dedicated exclusively to this service (including administration of the tests and scoring) and must be completed on the same day,

and

c. the start and stop time(s) must be recorded in the patient's medical record.

K032	Specific neurocognitive assessment	51.70

[Commentary:

Examples of neurocognitive assessment batteries which would be acceptable are the short form of the Behavioral Neurology Assessment (BNA) or the Dementia Rating Scale (DRS). The Mini-Mental State Examination ("Folstein") test is not considered acceptable for this purpose.]

Home care application

The service rendered by the most responsible physician for completion and submission of a home care service request form to a Community Care Access Centre (CCAC) on behalf of a patient for whom the physician provides on-going medical care. The amount payable for this service is as shown and is in addition to the assessment fee payable, where applicable. The amount payable for completion of the home care service request form if completed in whole or in part by a person other than the physician or the physician's employee is nil.

K070	Application	17.45

Home care supervision

The service rendered by the most responsible physician for personally providing medical advice, direction or information in response to an oral or other inquiry from health care staff of a Community Care Access Centre (CCAC) or CCAC contractor on behalf of a patient for whom the physician provides on-going medical care. The date, question, response and identity of the health care staff must be recorded in the patient's medical record. The amount payable for home care supervision without the required record of service in the patient's medical record is nil. The amount payable for home care supervision rendered on the same day as a consultation or visit by the same physician with the same patient is nil.

K071	Acute home care supervision (maximum 1 every 2 weeks for the first 12 weeks following admission to home care program)	10.95
K072	Chronic home care supervision (maximum 1 per month commencing in the 13th week following admission to the home care program)	10.95

Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation (MTO)

Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation (MTO) requires providing to MTO information that satisfies the requirements of the *Highway Traffic Act* or any applicable regulations, and includes providing any additional information to MTO regarding a previous report related to the same medical condition.

K035	Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation	34.85

Claims submission instruction:

Claims in excess of one per 12 month period by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

Northern Health Travel Grant Application Form

K036	Completion of Northern Health Travel Grant Application Form	10.25

[Commentary:

K036 is payable to both the referring physician and specialist physician.]

Long-Term Care Application

The service rendered for completion and submission of a health report form to a Community Care Access Centre (CCAC) on behalf of a patient who is applying for admission to a Long-Term Care facility.

K038	Completion of Long-Term Care health report form	41.00

ALLERGY

Since the Royal College of Physicians and Surgeons of Canada has not set a standard for "Allergy Specialist", fees for consultations and visits shall be payable to an allergist according to his or her own General or Specialty listings, except as follows.

CLINICAL INTERPRETATION BY AN IMMUNOLOGIST

Clinical Interpretation by an immunologist requires review of clinical data and interpretation of diagnostic tests and the results of related assessments in order to arrive at an opinion as to the nature of the patient's condition. The physician must submit his/her findings, opinions, and recommendations in writing to the patient's physician.

K399 Clinical interpretation by an immunologist 29.05

Payment rule:
This service is not eligible for payment when rendered in association with a consultation on the same patient by the same physician.

CONSULTATIONS AND VISITS

ANAESTHESIA (01)

GENERAL LISTINGS

Consultation

A015	Consultation	103.85

Payment rule:
The routine pre-anaesthetic evaluation of the patient required by the *Public Hospitals Act* does not constitute a consultation, regardless of where and when this evaluation is performed.

A016	Repeat consultation	50.75

Limited consultation for acute pain management

A limited consultation for acute pain management is a consultation which takes place when a physician is requested by another physician to see a hospital in-patient because of the complexity or severity of the acute pain condition.

A215	Limited consultation for acute pain management in association with special visit to hospital in-patient	46.20

Claims submission instruction:

When providing this service to a hospital in-patient in association with a special visit premium, submit claim using A215 and the appropriate special visit premium beginning with a "C" prefix.

[Commentary:
This service is not eligible for payment if performed for management of chronic pain or management of routine post-operative pain.]

A013	Specific assessment	46.20
A014	Partial assessment	30.10

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C015	Consultation - subject to the same conditions as A015	103.85
C016	Repeat consultation	50.75
C215	Limited consultation for acute pain management - subject to the same conditions as A215	46.20
C013	Specific assessment	46.20
C014	Specific re-assessment	27.25

Subsequent visits

C012	- first five weeks	per visit	29.20
C017	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C019	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

	See General Preamble GP31 for terms and conditions.	
C122	- day following the hospital admission assessment	55.45
C123	- second day following the hospital assessment	55.45
C124	- day of discharge	55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30) per visit	29.20
C018	Concurrent care per visit	29.20
C982	Palliative care (see General Preamble GP35) per visit	29.20

CONSULTATIONS AND VISITS

CARDIOLOGY (60)

For services not listed, refer to Internal Medicine Section

GENERAL LISTINGS

A605	Consultation		127.50
A675	Limited consultation		75.35
A606	Repeat consultation		75.35
A603	Medical specific assessment		58.25
A604	Medical specific re-assessment		45.90
A601	Complex medical specific re-assessment		53.15
A608	Partial assessment		30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C605	Consultation		127.50
C675	Limited consultation		75.35
C606	Repeat consultation		75.35
C603	Medical specific assessment		58.25
C604	Medical specific re-assessment		45.90
C601	Complex medical specific re-assessment		53.15

Subsequent visits

C602	- first five weeks	per visit	29.20
C607	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C609	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C608	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

CONSULTATIONS AND VISITS

CARDIOVASCULAR & THORACIC SURGERY (09)

GENERAL LISTINGS

A095	Consultation	66.30
A935	Special surgical consultation (see General Preamble GP17)	127.50
A096	Repeat consultation	46.30
A093	Specific assessment	41.20
A094	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C095	Consultation	81.60
C935	Special surgical consultation (see General Preamble GP17)	127.50
C096	Repeat consultation	46.30
C093	Specific assessment	41.20
C094	Specific re-assessment	25.85

Subsequent visits

C092	- first five weeks	per visit	29.20
C097	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C099	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C098	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W095	Consultation	66.30
W096	Repeat consultation	46.30

CONSULTATIONS AND VISITS

CLINICAL IMMUNOLOGY (62)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A625	Consultation		127.50
A525	Limited consultation		75.35
A626	Repeat consultation		75.35
A623	Medical specific assessment		58.25
A624	Medical specific re-assessment		45.90
A621	Complex medical specific re-assessment		53.15
A628	Partial assessment		30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C625	Consultation	127.50
C525	Limited consultation	75.35
C626	Repeat consultation	75.35
C623	Medical specific assessment	58.25
C624	Medical specific re-assessment	45.90
C621	Complex medical specific re-assessment	53.15

Subsequent visits

C622	- first five weeks	per visit	29.20
C627	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C629	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C628	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

CONSULTATIONS AND VISITS

COMMUNITY MEDICINE (05)

GENERAL LISTINGS

A055	Consultation	75.35
A405	Limited consultation	58.25

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C055	Consultation	75.35
C405	Limited consultation	58.25

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W055	Consultation	75.35
W405	Limited consultation	58.25

EMERGENCY DEPARTMENT - PHYSICIAN ON DUTY

H055	Consultation (see General Preamble GP17)	86.10

Note:

1. See General Preamble GP35 for definitions and conditions for physicians on duty.
2. All other consultations and visits - use the listings for Family Practice & Practice In General.

CONSULTATIONS AND VISITS

GASTROENTEROLOGY (41)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A415	Consultation		127.50
A545	Limited consultation		75.35
A416	Repeat consultation		75.35
A413	Medical specific assessment		58.25
A414	Medical specific re-assessment		45.90
A411	Complex medical specific re-assessment		53.15
A418	Partial assessment		30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C415	Consultation		127.50
C545	Limited consultation		75.35
C416	Repeat consultation		75.35
C413	Medical specific assessment		58.25
C414	Medical specific re-assessment		45.90
C411	Complex medical specific re-assessment		53.15

Subsequent visits

C412	- first five weeks	per visit	29.20
C417	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C419	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C418	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

GENERAL THORACIC SURGERY (64)

GENERAL LISTINGS

A645	Consultation	81.60
A935	Special surgical consultation (see General Preamble GP17)	127.50
A646	Repeat consultation	46.30
A643	Specific assessment	41.20
A644	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C645	Consultation	81.60
C935	Special surgical consultation (see General Preamble GP17)	127.50
C646	Repeat consultation	46.30
C643	Specific assessment	41.20
C644	Specific re-assessment	25.85

Subsequent visits

C642	- first five weeks	per visit	29.20
C647	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C649	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C648	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W645	Consultation	81.60
W646	Repeat consultation	46.30

CONSULTATIONS AND VISITS

GENETICS (22)

GENERAL LISTINGS

A225	Consultation*	142.80
A325	Limited consultation	75.35
A226	Repeat consultation	75.35
A221	Genetic minor assessment	30.10

Genetic assessment

A Genetic Assessment is a time based service that requires interviewing the appropriate family members, collection and assessment of adequate clinical and genetic data to make a diagnosis, construction/revision of a pedigree, and assessment of the risk to persons seeking advice. It also includes sharing this information and any options with the appropriate family members. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP6, GP37 for definitions and time-keeping requirements.

K016	Genetic assessment, patient or family	per unit	61.05

Payment rule:
This service is limited to 4 units per patient per day.

Genetic care

Genetic care is a time based service payable for rendering a genetic assessment. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP6, GP37 for definitions and time-keeping requirements.

K222	Genetic care, patient or family	per unit	61.05

Payment rule:
This service is limited to 4 units per patient, per day.

Clinical interpretation by a Geneticist

Clinical interpretation by a Geneticist requires interpretation of pertinent pedigrees (which must contain a comprehensive ancestral history), and/or cytogenetic, biochemical, or molecular genetic reports. The service must be requested in writing by a physician who is participating in the patient's care and the geneticist must submit his/her findings, opinions, and recommendations in writing to the referring physician.

K223	Clinical interpretation	28.80

Payment rule:
This service is not eligible for payment when rendered in association with a consultation on the same patient.

Genetic family counselling

Genetic family counselling is counselling dedicated to an educational dialogue between the physician and one or more family members, guardians of a genetic patient or patient's representative for the purpose of providing information regarding treatment options and prognosis. The claim is submitted under the genetic patient's health number.

K044	Genetic family counselling	per unit	51.70

Note:
Unit means ½ hour or major part thereof - see General Preamble GP6, GP37 for definitions and time keeping requirements.

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C225	Consultation*	142.80
C325	Limited consultation	75.35
C226	Repeat consultation	75.35

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W225	Consultation*	142.80
W325	Limited consultation	75.35
W226	Repeat consultation	75.35

Note:
*A consultation is payable at nil if a genetic assessment (K016) or genetic care (K222) has previously been claimed by the same physician.

GENERAL LISTINGS

A075	Consultation	142.80

Comprehensive geriatric consultation

A comprehensive geriatric consultation is a consultation performed by a physician with a certificate of special competence in Geriatrics on a patient at least 75 years of age where the physician spends at least 75 minutes with the patient exclusive of time spent rendering any other service to the patient.

A775	Comprehensive geriatric consultation	183.60

Payment rules:

1. The consultation must be scheduled at least one day before the service is rendered.
2. A comprehensive geriatric consultation is only eligible for payment if this service has not been rendered on the same patient by the same consultant within the previous 2 years.

A375	Limited consultation	75.35
A076	Repeat consultation	75.35
A073	Medical specific assessment	58.25
A074	Medical specific re-assessment	45.90
A071	Complex medical specific re-assessment	53.15
A078	Partial assessment	30.10

E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C075	Consultation	142.80
C775	Comprehensive geriatric consultation - subject to the same conditions as A775	183.60
C375	Limited consultation	75.35
C076	Repeat consultation	75.35
C073	Medical specific assessment	58.25
C074	Medical specific re-assessment	45.90
C071	Complex medical specific re-assessment	53.15

HAEMATOLOGY (61)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A615	Consultation		127.50
A655	Limited consultation		75.35
A616	Repeat consultation		75.35
A613	Medical specific assessment		58.25
A614	Medical specific re-assessment		45.90
A611	Complex medical specific re-assessment		53.15
A618	Partial assessment		30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C615	Consultation		127.50
C655	Limited consultation		75.35
C616	Repeat consultation		75.35
C613	Medical specific assessment		58.25
C614	Medical specific re-assessment		45.90
C611	Complex medical specific re-assessment		53.15

Subsequent visits

C612	- first five weeks	per visit	29.20
C617	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C619	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C618	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

GENERAL LISTINGS

A135	Consultation		127.50
A435	Limited consultation		75.35
A136	Repeat consultation		75.35
A133	Medical specific assessment		58.25
A134	Medical specific re-assessment		45.90
A131	Complex medical specific re-assessment		53.15
A138	Partial assessment		30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C135	Consultation		127.50
C435	Limited consultation		75.35
C136	Repeat consultation		75.35
C133	Medical specific assessment		58.25
C134	Medical specific re-assessment		45.90
C131	Complex medical specific re-assessment		53.15

Subsequent visits

C132	- first five weeks	per visit	29.20
C137	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C139	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C138	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W235	Consultation		127.50
W435	Limited consultation		75.35
W236	Repeat consultation		75.35

Admission assessment

W232	- Type 1		61.00
W234	- Type 2		17.75
W237	- Type 3		30.70
W239	Annual physical examination		61.00
W134	General re-assessment of patient in nursing home (as per the *Nursing Homes Act*)*		17.75

Note:
*May only be claimed 6 months after Annual Health Examination (as per the *Nursing Homes Act*)

Subsequent visits (see General Preamble GP34)

	Chronic care or convalescent hospital		
W132	- first 4 subsequent visits per patient per month	per visit	29.20
W131	- additional subsequent visits (maximum of 6 per patient per month)	per visit	13.80
W982	- palliative care (see General Preamble GP35)	per visit	29.20
	Nursing home or home for the aged		
W133	- first 2 subsequent visits per patient per month	per visit	22.55
W138	- subsequent visits per month (maximum of 3 per patient per month)	per visit	13.80
W972	- palliative care (see General Preamble GP35)	per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55

CONSULTATIONS AND VISITS

LABORATORY MEDICINE (28)

The following fees are applicable to specialists in Haematopathology, Neuropathology, Medical Biochemistry, Medical Microbiology, Anatomic and General Pathology.

GENERAL LISTINGS

A285	Consultation	96.95
A286	Limited consultation	64.70
A586	Repeat consultation	64.70
A283	Medical specific assessment	50.50
A284	Partial assessment	30.10
E078	- chronic disease assessment premium (see General Preamble GP21) add 40%	

Diagnostic consultation

A diagnostic laboratory medicine consultation is the service rendered when tissue, slides, and/or specimens prepared in one institution or facility are referred to a second laboratory medicine physician in a different institution or facility, for a written opinion. The specific elements are the same as for the L800 series of codes (see page J38).

A585	Diagnostic consultation	64.70

Payment rules:

1. A diagnostic laboratory medicine consultation is not eligible for payment when tissues, slides and/or specimens from a different institution or facility are used for comparison purposes with tissues, slides and/or specimens done in the consultant's institution or facility.
2. With the exception of those services set out in the section, "Special Procedures and Interpretation – Histology or Cytology", any other services rendered by the physician in association with a diagnostic laboratory medicine consultation are not eligible for payment.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C285	Consultation	96.95
C286	Limited consultation	64.70
C586	Repeat consultation	64.70
C283	Medical specific assessment	50.50
C585	Diagnostic consultation - subject to the same conditions as A585	64.70
C288	Concurrent care per visit	29.20

CONSULTATIONS AND VISITS

NEUROLOGY (18)

GENERAL LISTINGS

A185	Consultation	127.50
A385	Limited consultation	75.35
A186	Repeat consultation	75.35
A183	Medical specific assessment	58.25
A184	Medical specific re-assessment	45.90
A181	Complex medical specific re-assessment	53.15
A188	Partial assessment	30.10
E078	- chronic disease assessment premium (see General Preamble GP21) add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C185	Consultation	127.50
C385	Limited consultation	75.35
C186	Repeat consultation	75.35
C183	Medical specific assessment	58.25
C184	Medical specific re-assessment	45.90
C181	Complex medical specific re-assessment	53.15

Subsequent visits

C182	- first five weeks	per visit	29.20
C187	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C189	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C188	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W185	Consultation	127.50
W385	Limited consultation	75.35
W186	Repeat consultation	75.35
W184	General re-assessment of patient in nursing home (as per the *Nursing Homes Act*)*	17.75

Note:

*May only be claimed 6 months after Annual Health Examination (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP34)

	Chronic care or convalescent hospital		
W182	- first 4 subsequent visits per patient per month	per visit	29.20
W181	- additional subsequent visits (maximum of 6 per patient per month)	per visit	13.80
W982	- palliative care (see General Preamble GP35)	per visit	29.20
	Nursing home or home for the aged		
W183	- first 2 subsequent visits per patient per month	per visit	22.55
W188	- subsequent visits per month (maximum of 3 per patient per month)	per visit	13.80
W972	- palliative care (see General Preamble GP35)	per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55

CONSULTATIONS AND VISITS

NEUROSURGERY (04)

GENERAL LISTINGS

A045	Consultation	102.00
A935	Special surgical consultation (see General Preamble GP17)	127.50
A046	Repeat consultation	51.45
A043	Specific assessment	51.45
A044	Partial assessment	26.50

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C045	Consultation	102.00
C935	Special surgical consultation (see General Preamble GP17)	127.50
C046	Repeat consultation	51.45
C043	Specific assessment	51.45
C044	Specific re-assessment	26.50

Subsequent visits

C042	- first five weeks	per visit	29.20
C047	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C049	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C048	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W045	Consultation	102.00
W046	Repeat consultation	51.45

GENERAL LISTINGS

Consultation

A635	Consultation	65.70

Special Nuclear Medicine consultation

A special nuclear medicine consultation is payable when all components of a regular nuclear medicine consultation are met but, because of the very complex, obscure or serious nature of the problem, the physician is required to spend a minimum of 50 minutes with the patient in consultation.

A835	Special nuclear medicine consultation	127.50

Payment rule:
When a nuclear medicine consultation or repeat consultation is rendered in conjunction with a nuclear medicine study, only the P_2 professional fee is payable for the study (rather than the P_1 professional fee).

Diagnostic consultation

A diagnostic nuclear medicine consultation is the service rendered:

a. when nuclear medicine studies rendered at one institution or facility are referred to a nuclear medicine specialist in a different institution or facility for a written opinion. In this case, the specific elements are the same as the nuclear medicine professional component P_2 (see page B1);

or

b. when a nuclear medicine specialist is required to make a special visit at evening or night (17:00h to 07:00h) or on a Saturday, Sunday, or holiday to consult on the advisability of performing a nuclear medicine procedure, which eventually is not done. In this case, the specific elements are the same as for consultations.

A735	Diagnostic consultation	29.20

Payment rule:
A diagnostic nuclear medicine consultation is not eligible for payment when studies rendered in a different institution or facility are used for comparison purposes with nuclear medicine studies rendered in the consultant's institution or facility.

A636	Repeat consultation	45.10
A638	Partial assessment	30.10

GENERAL LISTINGS

A265	Consultation	142.80

Neurodevelopmental consultation

Neurodevelopmental consultation is payable when the physician provides all the elements of A265 for an infant, child or adolescent with complex neurodevelopmental conditions e.g. autism, global development disorders etc., and must include a minimum of 120 minutes of direct patient contact with the patient and caregiver. The start and stop time must be recorded in the patient's permanent medical record. Maximum one per patient per physician every five years.

A667	Neurodevelopmental consultation	255.00

Note:
Neurodevelopmental consultations for less complex conditions, e.g. attention deficit disorder, are payable at a lesser fee.

Prenatal consultation

A prenatal consultation is the service rendered by a paediatrician upon request of a physician who considers a fetus of greater than 20 weeks gestation to be at risk or in jeopardy by reason of continuation of pregnancy in the presence of maternal and/or fetal distress.

[Commentary:
A prenatal consultation by a paediatrician does not preclude the paediatrician from claiming a post-natal consultation on the infant.]

A665	Prenatal consultation	68.15
A565	Limited consultation	75.35
A266	Repeat consultation	75.35
A263	Medical specific assessment	58.25
A264	Medical specific re-assessment	45.90
A661	Complex medical specific re-assessment	53.15
A007	Intermediate assessment or well baby care	31.45
A261	Minor assessment	17.75
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%

Annual health examination

K267	- child after second birthday	30.40
K269	- adolescent	61.00

Note:
Diagnostic interview and/or counselling with child and/or parent - see listings in Family Practice & Practice in General.

Paediatric adolescent care

Paediatric adolescent care is payable for care rendered to patients aged 9 to 17 inclusive for the purpose of addressing concerns related to adolescence. See General Preamble GP6, GP36, GP37, for additional information and requirements for this service.

K120	Paediatric adolescent care	per unit	62.20

Payment rule:
This service is only payable to paediatricians with either a minimum of two years experience in an adolescent medicine practice (where a minimum of 50% of patients seen were adolescents) or fellowship training in adolescent medicine.

[Commentary:

1. Care rendered by physicians who do not meet this requirement is still insured but payable under another fee schedule code e.g. Primary Mental Health Care (K005).
2. Note that this service is not restricted to "adolescents" as defined in the definitions section (ages 16 or 17) but is payable for services rendered to patients aged 9 to 17 inclusive.]

GENERAL LISTINGS

A315	Consultation		142.80
A515	Limited consultation		75.35
A316	Repeat consultation		75.35
A313	Medical specific assessment		58.25
A310	Medical specific re-assessment		45.90
A311	Complex medical specific re-assessment		53.15
A318	Partial assessment		30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C315	Consultation	142.80
C515	Limited consultation	75.35
C316	Repeat consultation	75.35
C313	Medical specific assessment	58.25
C314	Medical specific re-assessment	45.90
C311	Complex medical specific re-assessment	53.15

Subsequent visits

C312	- first five weeks	per visit	29.20
C317	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C319	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C318	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W515	Consultation		142.80
W310	Limited consultation		75.35
W516	Repeat consultation		75.35

Admission assessment

W512	- Type 1		61.00
W514	- Type 2		17.75
W517	- Type 3		30.70
W419	Annual physical examination		61.00
W314	General re-assessment of patient in nursing home*		17.75

Note:
*May only be claimed 6 months after Annual Health Examination (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP34)

	Chronic care or convalescent hospital		
W312	- first 4 subsequent visits per patient per month	per visit	29.20
W311	- additional subsequent visits (maximum of 6 per patient per month)	per visit	13.80
W982	- palliative care (see General Preamble GP35)	per visit	29.20
	Nursing home or home for the aged		
W313	- first 2 subsequent visits per patient per month	per visit	22.55
W318	- subsequent visits per month (maximum of 3 per patient per month)	per visit	13.80
W972	- palliative care (see General Preamble GP35)	per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55

GENERAL LISTINGS

A195	Consultation	153.00
A895	Consultation in association with special visit to hospital or long-term care in-patient	178.50

Geriatric psychiatric consultation

Geriatric psychiatric consultation is payable to a psychiatrist for a patient aged 75 years or older and must include all the elements of A195 and a minimum of 75 minutes of direct contact with the patient exclusive of discussion with caregivers or any separately payable services. The consultation must be scheduled a minimum of 24 hours prior to the visit. The start and stop time must be recorded in the patient's permanent medical record. Maximum one per patient per physician every 5 years. Geriatric psychiatric consultations that do not conform with the above or are delegated in a clinic teaching unit to an intern, resident or fellow are payable as a lesser consultation or visit.

A795	Geriatric psychiatric consultation	183.60

Neurodevelopmental consultation

Neurodevelopmental consultation is payable when the physician provides all the elements of A195 for an adult with complex neurodevelopmental conditions e.g. autism, global developmental disorders etc., and must include a minimum of 120 minutes of direct contact with the patient and caregiver. The start and stop times must be recorded in the patient's permanent medical record. Maximum one per patient per physician every 5 years.

A695	Neurodevelopmental consultation	255.00

Note:
Neurodevelopmental consultations for children or adolescents or for less complex conditions e.g. attention deficit disorder are payable at a lesser fee.

A395	Limited consultation	75.35
A196	Repeat consultation	75.35
A193	Specific assessment	58.25
A194	Partial assessment	30.10

Consultation on behalf of disturbed child (including report)

A197	- consultative interview with parents	163.20
A198	- consultative interview with child	163.20

Note:
A197, A198 are considered as consultations. A197, A198 are not to be used when claiming assessment conference with parents. These should be claimed as family therapy.

EMERGENCY OR OUT-PATIENT DEPARTMENT (ODP)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C895	Consultation	178.50
C395	Limited consultation	75.35
C196	Repeat consultation	75.35
C795	Geriatric psychiatric consultation - subject to same conditions as A795	183.60
C695	Neurodevelopmental consultation - subject to same conditions as A695	255.00
C193	Specific assessment	58.25
C194	Specific re-assessment	45.90

Subsequent visits

C192	- first five weeks	per visit	29.20
C197	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C1	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C198	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W895	Consultation	178.50
W795	Geriatric psychiatric consultation - subject to same conditions as A795	183.60
W695	Neurodevelopmental consultation - subject to same conditions as A695	255.00
W395	Limited consultation	75.35
W196	Repeat consultation	75.35

CONSULTATIONS AND VISITS

RADIATION ONCOLOGY (34)

GENERAL LISTINGS

A345	Consultation		127.50
A745	Limited consultation		75.35
A346	Repeat consultation		75.35
A343	Medical specific assessment		58.25
A340	Medical specific re-assessment		45.90
A341	Complex medical specific re-assessment		53.15
A348	Partial assessment		30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C345	Consultation		127.50
C745	Limited consultation		75.35
C346	Repeat consultation		75.35
C343	Medical specific assessment		58.25
C344	Medical specific re-assessment		45.90
C341	Complex medical specific re-assessment		53.15

Subsequent visits

C342	- first five weeks	per visit	29.20
C347	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C349	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C348	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

CONSULTATIONS AND VISITS

RESPIRATORY DISEASE (47)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A475	Consultation		127.50
A575	Limited consultation		75.35
A476	Repeat consultation		75.35
A473	Medical specific assessment		58.25
A474	Medical specific re-assessment		45.90
A471	Complex medical specific re-assessment		53.15
A478	Partial assessment		30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C475	Consultation		127.50
C575	Limited consultation		75.35
C476	Repeat consultation		75.35
C473	Medical specific assessment		58.25
C474	Medical specific re-assessment		45.90
C471	Complex medical specific re-assessment		53.15

Subsequent visits

C472	- first five weeks	per visit	29.20
C477	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C479	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C478	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

CONSULTATIONS AND VISITS

RHEUMATOLOGY (48)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A485	Consultation	127.50
A595	Limited consultation	75.35
A486	Repeat consultation	75.35
A483	Medical specific assessment	58.25
A484	Medical specific re-assessment	45.90
A481	Complex medical specific re-assessment	53.15
A488	Partial assessment	30.10
E078	- chronic disease assessment premium (see General Preamble GP21)	add 40%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C485	Consultation	127.50
C595	Limited consultation	75.35
C486	Repeat consultation	75.35
C483	Medical specific assessment	58.25
C484	Medical specific re-assessment	45.90
C481	Complex medical specific re-assessment	53.15

Subsequent visits

C482	- first five weeks	per visit	29.20
C487	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C489	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C488	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

CONSULTATIONS AND VISITS

UROLOGY (35)

GENERAL LISTINGS

A355	Consultation*		66.30
A935	Special surgical consultation (see General Preamble GP17)		127.50
A356	Repeat consultation*		45.85
A353	Specific assessment*		39.70
A354	Partial assessment		22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C355	Consultation*		66.30
C935	Special surgical consultation (see General Preamble GP17)		127.50
C356	Repeat consultation*		45.85
C353	Specific assessment*		39.70
C354	Specific re-assessment		25.15

Subsequent visits

C352	- first five weeks	per visit	29.20
C357	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C359	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		55.45
C123	- second day following the hospital assessment		55.45
C124	- day of discharge		55.45
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C358	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

PREAMBLE

SPECIFIC ELEMENTS

In addition to the common elements, Clinical Procedures Associated with Diagnostic Radiological Examinations include the following specific elements.

A. Supervising the preparation of and/or preparing the patient for the procedure(s).

B. Performing the procedure(s) including the introduction of any contrast media and carrying out all appropriate recovery room procedures including transfer of the patient to the recovery room, ongoing monitoring and detention during the immediate post-procedure and recovery period.

C. Making arrangements for any related assessments or procedures, including obtaining any specimens from the patient and interpretation of any results where appropriate.

D. Where indicated, making or supervising the making of arrangements for follow-up care, and post-procedure monitoring of the patient's condition, including intervening, until the next insured service.

E. Discussion with, providing any advice and information and prescribing therapy to the patient or the patient's representative(s), whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies and personnel for the specific elements

- **a.** For services not identified with prefix # for all elements.
- **b.** For services identified with prefix # for any aspect(s) of A, C, D and E that is(are) performed in a place other than the place in which the procedure is performed.

Radiological services may be claimed in addition. See Diagnostic Radiology for the appropriate fees.

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

ANGIOGRAPHY

Note:
Selective coronary catheterization including angiogram, see Z442 and G297, Diagnostic and Therapeutic Procedures - Angiography.

By catheterization - abdominal, thoracic, cervical or cranial

		Spec	Anae
# J021	- insertion of catheter (including cut down, if necessary) and injection, if given	111.00	6
# J022	- selective catheterization - add to catheter insertion fee (per vessel, to maximum of 4) each	55.00	
# J014	- selective catheterization for spinal and parathyroid angiography ("Selective" means manipulation of the catheter from the vessel of introduction into a branch tributary, or cardiac chamber with angiogram(s)) - add to catheter insertion fee	27.35	
# J056	- transcatheter fibrinolytic therapy	418.05	6
N107	Extracranial approach to include balloon catheter techniques	855.80	15
N118	Carotid-cavernous fistula; extracranial approach to include balloon catheter techniques	747.60	15
# J058	Vascular stenting	72.90	6

Note:
J058 claimed same patient same day as G298 is payable at nil.

		Spec	Anae
# J066	Renal angioplasty	314.45	6

Carotid angiogram

		Spec	Anae
# J031	- direct puncture	87.55	6
# J025	Transluminal angioplasty including angiography (if anatomy is known), with or without pressure measurements - one or more site(s) or vessel(s)	285.80	6

Note:

1. If anatomy unknown at time of procedure, claim J021 and/or J022 at 50%. For simultaneous bilateral punctures and angioplasties, the amount payable for the second angioplasty is reduced by 50%.
2. J021 & J022 may not be claimed with J025 if anatomy is known.

		Spec	Anae
# J067	Spinal angiography for AV malformation, per vessel, maximum of 12 vessels per side	27.40	6

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

ANGIOGRAPHY

		Spec	Anae
# J048	Percutaneous trans-hepatic catheter portal venography	223.25	6
	Peripheral arteriogram		
# J027	- direct puncture	55.00	6
	Peripheral venogram		
# J026	- direct puncture	44.15	6
# J033	Splenoportogram	87.55	6
# J034	Trans-lumbar aortogram	87.55	6
	Vertebral angiogram		
# J032	- direct puncture or by retrograde brachial injection	87.55	6
	Embolization (e.g. for treatment of haemangioma or renal carcinoma)		
# J040	- first vessel, claim appropriate angiographic procedural and radiological fees plus	75.55	
# J047	- each additional vessel catheterized and occluded per vessel	35.40	
# J023	Intra-arterial infusion of drugs e.g. for control of gastrointestinal haemorrhage - claim appropriate angiographic procedural and radiological fees plus a per diem supervision fee of	21.20	
# J035	Pressure measurements during angiography	21.20	

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

		Spec	Anae
# J001	Arthrogram, tenogram or bursogram	21.20	6
	Note: Biliary duct calculus manipulation etc. (see Z562 listed in Digestive System - Biliary Tract.)		
	Bronchial brushing		
# J024	- unilateral	87.55	6
# J044	- bilateral	131.45	6
	Bronchogram		
# J002	- unilateral	26.30	6
# J043	- bilateral	39.60	6
	Bronchogram with intra-tracheal catheter		
# J003	- unilateral	53.40	6
# J042	- bilateral	80.05	6
	Carotid or vertebral artery occlusion by detachable balloon		
# J050	- percutaneous	240.55	
# J053	Cavernosography	44.15	
# J005	Dacrocystogram	32.60	6
	Discogram		
# J006	- one disc	75.55	6
# J030	- each additional disc add	38.80	
	Embolization of spinal arteriovenous malformation		
# J049	- percutaneous	343.40	6
# J036	Fistula or sinus injection	21.20	
# J068	Hydrostatic/pneumatic reduction of intussusception	31.75	6
# J008	Hysterosalpingogram	44.15	6
# J004	Intramammary needling for localization under mammographic control	50.50	
# J009	Laryngogram	26.30	

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

		Spec	Anae
	Lymphangiogram		
# J010	- per side	75.55	
# J037	Mammary ductography	50.50	
# J011	Myelogram	75.55	6
# J038	- with supine views requiring removal and re-introduction of spinal needle ... add	21.20	
# J020	- with posterior fossa views ... add	21.20	
# J012	Nephrotomogram	-	6
# J060	Nephrostogram	21.20	
# J045	Percutaneous antegrade pyelogram	87.55	6
# J055	Percutaneous gastrostomy	160.60	
# J061	Percutaneous cecostomy	160.60	
# J062	Percutaneous cholecystostomy	160.60	
# J063	Percutaneous jejunostomy	186.30	
# J064	Exchange of drainage tubes, including supervision, imaging and hard copy film interpretation if any	52.15	
# J046	Percutaneous nephrostomy	160.60	6
# J041	Percutaneous removal of intravascular and intraureteric foreign bodies	211.95	IC
# J065	Dilation of non-vascular structures	18.25	6
# J059	Non-vascular stenting	72.90	
# J051	Percutaneous spinal cord puncture for syringogram	74.30	6
# J013	Percutaneous trans-hepatic cholangiogram	75.55	6
# J057	Transjugular intrahepatic portosystemic shunt (TIPS)	565.15	6
# J052	Positive contrast cisternogram	97.25	6
Z597	Intracavitary/intratumoural injections	70.75	6
# J039	Renal cyst puncture	87.55	6
# J018	Sialogram	32.60	6
# J007	Tomogram	-	6
# J028	Urethrogram, urethrocystogram, or intestinal conduit examination, cystogram	21.20	
# J029	Vasogram	58.35	6

Note:
Intubation of small intestine (see Z540 listed in Digestive System - Intestines (except rectum)).

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

NOT ALLOCATED

Skin testing

			T	P
G209	- technical component, to a maximum of 50 per year	per test	0.71	
G197	- professional component, to a maximum of 50 per year	per test		0.17

			Fee
G199	Insect venom skin testing including physician interpretation, to a maximum of 30 per year	per test	1.25
G195	Local anaesthetic hypersensitivity skin test, to a maximum of 25 per year	per test	1.05
G196	Penicillin hypersensitivity skin test, to a maximum of 15 per year	per test	1.05
E582	- when testing with penicillin minor determinant mixture outside a hospital setting	add	11.40

Physical urticaria challenges - to include at least 3 of the following:

a. assessment of dermographic challenge with 100, 250 or 500 gm needle, measuring immediate and delayed responses,

b. assessment of pressure challenge with 15 lbs. weight recording onset, peak, duration of response - immediate and delayed,

c. assessment of ice cube cold challenges,

d. assessment of cholinergic exercise challenge with use of treadmill or bicycle to target pulse rate greater or equal to 120 per minute and profuse sweating,

e. vibration effect of light and water,

f. histamine or methacholine

G213	Physical urticaria challenges	13.80

SPECIFIC ELEMENTS

Examination Under anaesthesia (EUA) (when sole procedure performed)

A. While this may be performed for diagnostic purposes, the specific elements are those for a therapeutic procedure.

B. EUA is payable only if sole procedure performed by examining physician. EUA claimed in conjunction with any other procedure is payable at nil.

C. Claims for EUA submitted without the applicable diagnostic code are payable at nil.

		Fee	Anae
Z432	EUA with or without intubation, and may include removal of vaginal foreign body	54.10	6
Z430	Provision of anaesthetic services for patients undergoing magnetic resonance imaging	-	6

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

		Fee	Anae
	Vascular Cannulation		
Z459	Arterial puncture	9.10	
# G268	Cannulation of artery for pressure measurements including cut down as necessary	31.25	
# G269	Cannulation of central vein for pressure measurements or for feeding line - not to be billed with right heart catheterization (Z439) or with Swan-Ganz catheter insertion	31.25	
# G270	Intraosseous infusion	23.90	
# G309	Umbilical artery catheterization (including obtaining of blood sample)	45.55	
	Venipuncture		
+ G480	- infant	9.25	
+ G482	- child	6.25	
+ G489	- adolescent or adult	2.32	
+ G483	Therapeutic venisection	9.70	
G282	Umbilical vein catheterization (including obtaining of blood sample)	19.90	
# Z438	Insertion of Swan-Ganz catheter (not included in anaesthetic, respiratory or critical care benefits)	162.50	6
# G304	- when dye dilution densitometry done in addition, to a maximum of 3, per Swan-Ganz insertion	49.35	
G360	- when thermal dilution studies done in addition by a physician, once a day to a maximum of 5 days	49.35	

Note:
When G296 is done in addition to Z438 use code G304 instead.

		Fee	Anae
# Z456	Insertion of permanent feeding line, e.g. Hickman or Broviac catheter	135.50	6
# Z457	Surgical removal or repair of implanted central venous catheter	39.45	6
# Z446	Insertion of subcutaneous venous access reservoir (chemoshunt)	135.50	6
# Z447	- revision same site	59.70	6

FOR ANTICOAGULANT SUPERVISION - LONG-TERM, TELEPHONE ADVICE

In addition to the common elements, the components of this service include the following specific elements.

A. Monitoring the condition of a patient with respect to anticoagulant therapy, including ordering blood tests, interpreting the results and inquiry into possible complications.

B. Adjusting the dosage of the anticoagulant therapy and, where appropriate, prescribing other therapy.

C. Discussion with, and providing advice and information to the patient or patient's representative(s), by telephone, on matters related to the service even when initiated by the patient or patient's representative(s).

D. Making arrangements for any related assessments, procedures or therapy and interpreting results as appropriate.

E. Providing premises, equipment, supplies and personnel for the specific elements.

			Fee
G271	Anticoagulant supervision - long-term, telephone advice	per month	10.60

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

CARDIOVASCULAR

BLOOD TRANSFUSIONS

			Fee	Anae
# G275	Exchange transfusion		205.45	

Note:
Assistant at exchange transfusion (see General Preamble GP51).

			Fee	Anae
# G280	Intra-uterine fetal transfusion - initial or subsequent		186.90	
G276	Donor cell pheresis (platelets or leukocytes)		15.35	

Therapeutic plasma exchange

			Fee	Anae
# G277	- initial and repeat, to a maximum of 5 per year	each	74.55	
# G278	- more than 5 per year	each	38.00	
# G272	Manual plasmapheresis (see General Preamble GP12)		I.C	

CARDIOVERSION

			Fee	Anae
# Z437	Cardioversion (electrical) - limit of three sessions per patient	per day	66.00	6

CARDIAC CATHETERIZATION

When more than one procedure is carried out at one sitting, the additional procedures are to be claimed at 50% of the listed benefits. (Z439 to G288, excluding G262 and G263).

HAEMODYNAMIC/FLOW/METABOLIC STUDIES

			Fee	Anae
	Right heart			
# Z439	- pressures only		154.10	6
	Left heart			
# Z440	- retrograde aortic		194.45	6
# Z441	- transeptal		274.40	6
# G296	Dye dilution densitometry and/or thermal dilution studies - benefit covers all studies on same day in cath lab		102.45	

Note:
When G296 is done in addition to Z438 use code G304 instead.

			Fee	Anae
# G299	Oximetry		102.45	
# G289	Fick determination		102.45	
# G300	Metabolic studies, e.g. coronary sinus lactate and pyruvate determinations		102.45	
# G301	Exercise studies during catheterization		113.00	
# G306	Isotope studies during cardiac catheterization		102.45	
# G305	Intracardiac phonocardiography		113.00	

ANGIOGRAPHY

			Fee	Anae
# G297	Angiograms (only two angiograms may be billed - one per right heart catheterization and one per left heart catheterization) irrespective of the number of chambers injected		109.65	

Bypass graft angiogram

# G509	- per graft injection		74.25	

Note:
Includes internal mammary artery implant.

Selective coronary catheterization

# Z442	- both arteries		267.45	6
# G263	- with other drug interventional studies	add	89.95	

Note:
Includes injection of intracoronary nitroglycerin.

Transluminal coronary angioplasty

# Z434	- one or more sites on a single major vessel		435.65	6
G262	- each additional major vessel	add	196.15	

Note:
If anatomy unknown at time of procedure, claim G297 at 50%.

# G298	Coronary angioplasty stent, per stent		72.90	

Note:
J058 claimed same patient same day as G298 is payable at nil.

Percutaneous angioplasty

# Z448	- aortic valve, pulmonic valve, pulmonary branch stenosis		487.90	20
# Z449	- for coarctation of aorta		383.40	20
# Z460	- closure of patent ductus arteriosis with umbrella		348.70	20
# Z461	- mitral valvuloplasty for rheumatic stenosis		523.00	

Note:
Z448 to Z461 includes angiography with or without pressure measurements.

Electrophysiology/Pacing

		Fee	Anae
	Endocardial activation mapping (includes insertion of electrodes and arrhythmia induction)		
# G176	- atrial	334.25	
# G177	- ventricular	416.80	
# G178	- catheter ablation therapy	352.05	
# G179	- repeated	111.20	
G115	External cardiac pacing (temporary transthoracic) once per 24-hour period	46.30	

Note:
G115 not to be claimed with G521, G522, G523, G395 and G391.

		Fee	Anae
# G249	Electrophysiologic measurements (includes one or all of sinus node recovery times, conduction times and refractory periods), includes insertion of electrodes	231.65	

ARRHYTHMIAS

Induction of arrhythmias

		Fee	Anae
	To include programmed electrical stimulation, drug provocation and termination of arrhythmia, if necessary - once per patient per 24 hours		
# G261	- atrial	331.05	
# G259	- ventricular	383.30	

Note:
G261, G259 not to be claimed with G521, G522, G523, G395 and G391.

		Fee	Anae
# G366	Testing of arrhythmias inductability by acute administration of anti-arrhythmic drugs to a maximum of 2 per 24 hours	148.50	
# Z443	Insertion of temporary endocardial electrode	154.10	6
# Z431	Repositioning of temporary endocardial electrode	64.25	6

Endomyocardial Biopsy

		Fee	Anae
# G288	- transvascular, right or left	175.20	

Tilt Table Testing of Vasomotor syncope

		Fee	Anae
# G314	- to include arterial cannulation, provocative and blocking drugs, physician must be continually present	112.00	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ELECTROCARDIOGRAPHY (ECG)

Fee

PREAMBLE

1. ECGs may be requested by a Registered Nurse in the Extended Class (RN(EC)) in non-urgent and non-acute circumstances. Physicians and hospitals should use Fee Codes G313 and G310 for requests by RN(EC)s.
2. An ECG ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department is insured when the ECG is rendered:
   - **a.** in connection with a dental surgical procedure provided by an oral and maxillofacial surgeon in a hospital and it is medically necessary for the patient to receive the dental surgical procedure in a hospital;

     or

   - **b.** on the order of an oral and maxillofacial surgeon who has reasonable grounds to believe that a dental surgical procedure, performed by an oral and maxillofacial surgeon, will be required in connection with the ECG and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.

		Fee
G175	Insertion of oesophageal electrode in monitoring position	21.85

		T	P
	Electrocardiogram - twelve lead		
+ G310	- technical component	6.75	
G313	- professional component - must include written interpretation		9.75
	STRESS TESTING		
	Maximal stress ECG		
	Maximal stress ECG (exhaustion, symptoms or ECG changes) or submaximal stress ECG (to target heart rate for patient) by a standard technique - with treadmill or ergometer and oscilloscopic continuous monitoring including ECGs taken during the procedure and resting ECGs before and after the procedure - physician must be in attendance at all times. The professional component includes the necessary clinical assessment immediately prior to testing.		
G315	- technical component	33.65	
G319	- professional component		59.30
	Dobutamine stress test		
G174	- technical component, when rendered outside of hospital ... add	37.00	
	Dipyramidole Thallium Stress Test		
G111	- technical component	41.10	
G112	- professional component		68.25

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

DIALYSIS

Note:
Team benefits to include listed items. This does not include preliminary investigation of the case.

Haemodialysis

		Asst	Fee	Anae
# R849	Initial and acute (includes both medical and surgical components)		621.35	6
# R850	Surgical component alone - insertion of Scribner shunt		313.25	6
G325	Medical component alone		308.00	
# G323	Acute, repeat - for the first 3 services		154.00	
# G083	Continuous venovenous haemodialysis - initial and acute (for the first 3 services)		369.65	
# G091	Continuous arteriovenous haemodialysis - initial and acute (for the first 3 services)		246.45	
# G085	Continuous venovenous haemofiltration - initial and acute (for the first 3 services)		369.65	
# G295	Continuous arteriovenous haemofiltration - initial and acute (for the first 3 services)		246.45	

Note:
Haemodialysis to include haemofiltration, haemoperfusion.

Continuous haemodiafiltration

		Asst	Fee	Anae
# G082	Continuous venovenous haemodiafiltration - initial and acute (for the first 3 services)		431.20	
# G092	Continuous arteriovenous haemodiafiltration - initial and acute (for the first 3 services)		308.00	
# G094	Chronic, continuous haemodiafiltration		65.05	

Slow continuous ultrafiltration

		Asst	Fee	Anae
# G090	Venovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		308.00	
# G294	Arteriovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		184.75	
# G096	Chronic, slow continuous ultrafiltration		65.05	

Revision of Scribner shunt

		Asst	Fee	Anae
# Z450	- single		102.55	6
# Z451	- both		152.40	6
# Z452	De-clotting of Scribner shunt		93.60	
# R843	Removal of cannula or A.V. shunt		81.45	6
# R827	Creation of A.V. fistula	5	360.25	6

Note:
R827 - see also listing under Cardiovascular System, Veins - Repair.

		Asst	Fee	Anae
# R841	Obliteration of A.V. fistula		82.55	6

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

DIALYSIS

Code	Procedure	Fee	Anae
	Bypass graft for haemodialysis		
# R851	- synthetic	444.70	7
# R840	- autogenous vein	424.10	7
# R833	Ligation or removal of bypass graft	82.55	6
	Subclavian or external jugular catheter for haemodialysis		
# G324	- insertion	93.60	
# G336	- revision	15.35	
# R848	Dialysis cannula insertion under vision into central line (excluding percutaneous)	219.15	6
# G099	Percutaneous insertion of permanent jugular/femoral dialysis catheter (including subcutaneous positioning)	135.80	
# G327	Insertion of femoral catheter for dialysis	70.25	
# G312	Thrombolytic instillation into temporary and permanent percutaneous catheters	15.40	
	Peritoneal dialysis		
# G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary)	199.55	
# G331	Repeat acute (up to 48 hours) - for the first 3 services	179.60	
# R852	Insertion of peritoneal cannula by laparotomy	186.95	6
# R885	Removal of peritoneal cannula by laparotomy	186.95	6
	Tenckhoff type peritoneal catheter		
# R853	- insertion, chronic by trocar	93.60	6
# R854	- removal	50.90	

		Fee	Anae
+ G369	B.C.G. inoculation, following tuberculin tests	5.30	
+ G370	Bursa, joint, ganglion or tendon sheath and/or aspiration	19.90	
G371	- each additional site or area, to a maximum of 3	10.00	

Note:
G370, G371 is not eligible for payment in addition to surgical benefits when performed at time of surgery.

CHEMONUCLEOLYSIS

Lateral discography

		Fee	Anae
# Z454	- first disc	74.75	6
G368	- if lumbosacral disc included add	54.40	
# G386	- second and subsequent discs each	38.45	

Injection for chemonucleolysis

		Fee	Anae
# G392	- initial injection	50.75	
# G393	- any subsequent injection at other levels each	25.35	
G396	Injections of extensive keloids	24.90	
# Z455	- under general anaesthesia	44.70	6

INTRAMUSCULAR, SUBCUTANEOUS OR INTRADERMAL

		Fee	Anae
G372	- with visit (each injection)	2.32	
G373	- sole reason (first injection)	5.30	
G372	- each additional injection	2.32	

Note:
G372, G373 includes interpretation.

ACTIVE IMMUNIZATION

Injection of unspecified agent

		Fee
G538	- with visit (each injection)	3.83
G539	- sole reason (first injection)	8.65
G538	- each additional injection	3.83

Injection of influenza agent

G590	- with visit	3.83
G591	- sole reason	8.65
G538	- each additional injection with non-influenza agents	3.83

Payment rule:
Where G539 is rendered to the same patient during the same visit at which G591 is rendered, the amount payable for G539 is reduced to amount payable for G538.

INTRALESIONAL INFILTRATION

+ G375	- one or two lesions	8.85
+ G377	- 3 or more lesions	13.30
G383	- extensive (see General Preamble GP12)	I.C

Note:
Intralesional injection of acne lesions with corticosteroids is not an insured service.

G462	Administration of oral polio vaccine	1.65
G384	Infiltration of tissues for trigger point	8.85
G385	- for each additional site (to a maximum of 2) add	4.55

INTRAVENOUS

+ G376	Newborn or infant	10.20
+ G379	Child, adolescent or adult	6.15

Note:

1. G376 or G379 apply to cryoprecipitate infusion.
2. G376 or G379 may not be claimed with x-rays as they are included in the service.
3. Except for G381 or G281, injections into established I.V. apparatus may not be claimed.

G389	Infusion of gamma globulin, initiated by physician, including preparation per patient, per day	13.90
+ G380	Cutdown including cannulation as necessary	27.05

		Fee	Anae
	Contact lens fitting		
G424	- includes follow-up for 3 months except for patients under 4 years of age at the time of the initial fitting	174.75	
G431	- under general anaesthesia add	41.60	6

[Commentary:
Follow up services are payable in addition to contact lens fitting (G424) for children under 4 years of age.]

G423	One eye only, when the other eye has been previously fitted by the same physician, with follow-up for 3 months	90.30	

Note:
G424, G423 - Contact lens fitting is not a benefit except under certain specific conditions. Please check with the Ministry of Health and Long-Term Care Medical Consultant.

G463	Hydrophilic Bandage lens fitting	90.30	
G453	Electro-oculogram - interpretation fee	41.60	
G426	Glaucoma provocative tests, including water drinking tests	9.70	
G427	Ophthalmodynamometry	9.60	
	Radioactive phosphorus examination		
G429	- anterior approach	42.45	
G430	- posterior approach	86.05	
G421	Subconjunctival or sub-Tenons capsule injection	27.70	

Note:
G429, G430, G421 - for bilateral procedures, add 50% of the listed benefit.

+ G435	Tonometry	5.10	

Note:
G435 may not be claimed in conjunction with an ophthalmological consultation or specific assessment as this is included in these services.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

OPHTHALMOLOGY

Colour vision detailed assessment

Colour vision detailed assessment (not to be claimed for screening tests such as Ishihara, HRR and University, etc.) only where underlying pathology is present or suspected. Requires that the following services are rendered: one of the screening tests and at least two (2) of the following detailed tests: 100 Hue, D-15, Lathony New Colour Test or anomaloscope test. To be performed where underlying pathology is present or suspect. Not to be performed as a routine screening test.

		T	P
G850	- technical component	20.90	
G438	- professional component		22.15

Dark adaptation curve (Goldmann adaptometer or equivalent)

G851	- technical component	31.35	
G437	- professional component		22.90

Electro-retinography with report

G852	- technical component	34.00	
+ G439	- professional component		24.00

Fluorescein angiography

G853	- technical component	22.50	
+ G425	- professional component		23.90

Fluorescein angioscopy

G854	- technical component	6.55	
+ G444	- professional component		7.00

Note:

G425, G853, G444, G854 - for bilateral procedures, add 50% of the listed benefit.

Hess screen examination

G855	- technical component	6.45	
G428	- professional component		6.85

Tonography (to include tonometry) with or without water

G856	- technical component	9.30	
G433	- professional component		9.90

Visual fields - kinetic (with permanent record)

G857	- technical component	4.50	
G436	- professional component		4.80

Visual fields - static

Visual fields static perimetry, only where underlying pathology is present or suspected. Requires that the following services are rendered: permanent record with measurement of a minimum of 72 points per eye, qualification of deficient points and monitoring of fixation.

G858	- technical component	13.65	
G432	- professional component		14.50

BASIC DIAGNOSTIC HEARING TESTS

Pure tone threshold audiometry with or without bone conduction

		T	P
G440	- technical component	8.80	
G525	- professional component		5.85

Pure tone threshold audiometry (with or without bone conduction) and speech reception threshold and/or speech discrimination scores.

		T	P
G441	- technical component	12.25	
G526	- professional component		12.70

ADVANCED DIAGNOSTIC HEARING TESTS

Impedance audiometry by manual or automated methods

		T	P
G442	- technical component	2.78	
+ G529	- professional component		1.86

Note:
G442, G529 may include stapedial reflex and/or compliance testing.

Sound field audiometry (infants and children)

		T	P
G448	- technical component	18.55	
G450	- professional component		5.70

Note:
The amount payable is reduced to nil if any claim is submitted for G525, G441 or G526 rendered to the patient on the same day.

Miscellaneous advanced testing e.g. recruitment, tests of malingering, central auditory and stapedial reflex decay tests - per test

			T	P
G443	- technical component, to a maximum of 3	per test	8.00	
G530	- professional component, to a maximum of 3	per test		5.95

Cortical Evoked Audiometry

		T	P1	P2
G143	- technical component	30.75		
G141	- professional component (P_1)		23.95	
G142	- interpretation only (P_2)			10.85

Note:
For cortical evoked audiometry, multiple frequency, as required by WSIB - see Appendix F.

Brain Stem Evoked Audiometry

		T	P1	P2
G146	- technical component	30.75		
G144	- professional component (P_1)		23.95	
G145	- interpretation only (P_2)			15.85

Note:
P_1 may only be claimed when physician performs the studies and interprets the results.

Electrocochleography (per ear): to include myringotomy if performed

		T	P
G815	- technical component	30.75	
G816	- professional component		104.45

DIAGNOSTIC BALANCE TESTS

Positional testing with electronystagmography (ENG)

		T	P
G104	- technical component	19.05	
G105	- professional component		18.30

Caloric testing with ENG

		T	P
G451	- technical component	19.05	
+ G533	- professional component		18.30

		Fee
G454	Stroboscopy	16.80
G191	Optokinetic tests	12.40
G108	Computerized rotation tests	20.20

DIAGNOSTIC TASTE TESTS

		Fee
+ G452	Electrogustometry or conventional taste tests	14.35
G534	Phonatory airflow study	10.95
G535	- with subglottic pressures	30.55
G532	Air insufflation test to assess benefit of tracheoesophageal puncture	27.70

TELEPHONE MANAGEMENT OF PALLIATIVE CARE

The provision by telephone of medical advice, direction or information at the request of the patient, patient's relative(s), patient's representative(s) or other caregiver(s), regarding a patient receiving palliative care at home. The service must be rendered personally by the physician and is eligible for payment only when a dated summary of the telephone call is recorded in the patient's medical record.

			Fee
G511	Telephone management regarding a patient receiving palliative care at home	per call	17.75

Payment Rules:

1. This service is limited to a maximum of two services per week.
2. This service is not eligible for payment if rendered the same day as a consultation, assessment, time-based service or other visit by the same physician.
3. This service is not eligible for payment if a claim is submitted for K071 or K072 for the same telephone call.
4. This service is only eligible for payment when rendered by the physician most responsible for the patient's care or by a physician substituting for this physician.

[Commentary:
This service is only eligible for payment when the patient is receiving palliative care in either the patient's home or the home of a family member or other individual with whom the patient is residing. See definitions of "home" and "palliative care" in the Definitions section of the General Preamble.]

BOTULINUM TOXIN

Botulinum Toxin intramuscular injection with botulinum toxin into peripheral muscle for treatment of focal spasticity secondary to an upper motor neuron disorder. The procedure is an insured service payable at nil unless rendered personally by a paediatrician, neurologist or physical medicine specialist or a physician with equivalent post-graduate training and experience with neuromuscular disorders. Maximum one botulinum toxin treatment of one or more muscles per patient every 10 weeks.

			Fee
G597	Injection into first muscle per day		20.40
G598	- each additional muscle same day as G597 when G597 is payable in full (maximum 8 per day)	add	10.20
G599	- with electromyographic (EMG) guidance of injection into one or more muscles when G597 is payable in full (maximum 1 per day)	add	20.40
E543	- use of disposable EMG hypodermic electrode outside hospital when G599 is payable in full (maximum 1 per patient per day)		30.60

Note:
Any EMG code other than G599 claimed for the same day same patient as botulinum toxin injection is performed is an insured service payable at nil.

[Commentary:
The above definitions and fees for botulinum toxin injection have been introduced on an interim basis and will be subject to a joint review by the Ministry and the Ontario Medical Association on or before February 1, 2004.]

PSYCHIATRY

Electroconvulsive therapy (ECT) cerebral - single or multiple

		Fee	Anae
# G478	- in-patient	62.20	6
# G479	- out-patient	65.25	6

Note:
Electrosleep therapy or Sedac therapy are not insured benefits.

RESPIRATORY DISEASE

		Fee	Anae
G404	Chronic ventilatory care outside an Intensive Care Unit	61.00	

Note:
Maximum 2 per week. Any other amount payable for consultations or assessments same patient, same physician, same day will be reduced to nil.

OBSTETRICS

PREAMBLE

11. Ordinary immediate care of the newborn is included in the labour-delivery fee and when the service is rendered by the anaesthetist, it is included in the anaesthetic benefit. A life threatening emergency situation requiring active resuscitation of the newborn provided by any physician may be claimed under codes G521, G522, G523. When indicated, endotracheal intubation and tracheo-bronchial toilet should be billed under G211 and not as G521, G522, G523.

12. When an obstetrician routinely transfers all newborns to another physician, the latter may not claim a consultation for these transferals. If the baby is well, the physician should claim newborn care in hospital plus attendance at maternal delivery (H007/H267) if this service is provided. If the baby is sick, the physician may claim a general assessment and attendance at maternal delivery (H007/H267) if this service is provided plus daily visits for as long as his/her services are required.

13. If an obstetrician who normally cares for newborns him/herself or transfers the care of newborns to a family physician, refers a newborn to a paediatrician because of the complexity, obscurity or seriousness of the case, the latter may claim for this service according to the following guidelines:

- **a.** If attendance at maternal delivery is provided, C263 may be claimed in addition to H267 if a general assessment of the baby is carried out. A postnatal consultation of the baby, (C265) may not be claimed in addition to attendance at maternal delivery (H267).
- **b.** If attendance at maternal delivery (H267) is not provided, a postnatal consultation (C265) may be claimed, if rendered, whether or not a prenatal consultation has already been claimed.

14. Physicians may claim for assisted breech delivery (P020) when the service includes spontaneous delivery to the umbilicus, with extraction of the shoulders, arms and head.

15. See General Preamble GP60 for After Hours Premiums.

16. If claims are being submitted in coded form, the obstetrician should add the suffix "A" to the listed procedural code, the assistant should add the suffix "B" to the listed procedural code, and the anaesthetist should add the suffix "C" to the listed procedural code.

OBSTETRICS

PRENATAL CARE

		Asst	Surg	Anae
P003	General assessment (major prenatal visit)		61.00	

Antenatal Preventative Health Assessment

The service rendered by the most responsible physician for conducting the initial review of antenatal risk. The review must examine all current psychosocial, genetic and medical issues affecting antenatal risk and must be documented in writing in the patient's permanent medical record. Maximum once per pregnancy. P005 rendered same patient same day same physician as any other consultation or visit except P003 and P004 is an insured service payable at nil.

P005	Antenatal preventative health assessment		41.65	
P004	Minor prenatal assessment		29.20	

Medical Management of Early Pregnancy - initial service

Medical management of early pregnancy - initial service is the service payable when a physician renders an initial assessment and administration of cytotoxic medication(s) for the termination of early pregnancy or missed abortion. The cost of the drug(s) is not included in the fee for the service.

A920	Medical management of early pregnancy - initial service		95.65	

Payment rules:

Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service) are not eligible for payment when rendered the same day to the same patient by the same physician as A920.

[Commentary:

As with all insured services, A920 must be provided in accordance with professional standards - such as those published by the Society of Obstetricians and Gynaecologists of Canada.]

Medical Management of Early Pregnancy - subsequent visit(s)

Medical management of early pregnancy - subsequent visit is for a visit that is a follow-up of A920, whether rendered by the same physician who rendered the A920, or another physician.

A921	Medical management of early pregnancy - subsequent visit(s)		31.45	

Payment rules:

1. Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service) are not eligible for payment when rendered the same day to the same patient by the same physician as this service.
2. A921 is limited to two per patient per pregnancy. Services in excess of this limit will be adjusted to another assessment fee.

OBSTETRICS

LABOUR - DELIVERY

		Asst	Surg	Anae
# P006	Vaginal		445.75	
# P020	Operative delivery, i.e. mid-cavity extraction or assisted breech delivery		477.15	6
# E502	- vaginal birth after caesarean section (VBAC) whether successful or unsuccessful add		51.00	
# P018	Caesarean section	6	514.85	7
# P041	Caesarean section including tubal interruption	6	539.95	7
# P042	Caesarean section including hysterectomy	8	734.35	8
# E500	- multiple births, any method of delivery - each child. . add		145.10	

Note:
If one child is born vaginally and the other(s) by caesarean section, claim P018, P041 or P042 plus one at 85% of P006 or P020, then E500 for third and subsequent births.

Attendance at labour

P038	- when patient transferred to another centre for delivery	211.20

Attendance at labour and delivery

Payable to a physician other than an obstetric consultant for attending labour and delivery when the physician either assists at vaginal delivery or surgery, gives anaesthetic at a caesarean section or operative delivery, or resuscitates the newborn.

P009	Attendance at labour and delivery	445.75

Note:
Anaesthesia or Assistant units are not eligible for payment when the same physician claims P009 on the same patient.

P010	Attendance of obstetric consultant(s) at delivery	211.20

Note:
Amount payable for attendance of a physician other than an obstetric consultant at only delivery is nil.

Special visit for first obstetrical delivery with sacrifice of office hours

Payable in addition to first obstetric delivery in calendar day. Maximum of one per physician per calendar day. See General Preamble GP44 for definition of special visit.

C989	- special visit for first obstetrical delivery with sacrifice of office hours add	36.30

Sole Delivery Premium

Payable in addition to labour and delivery fees P006A, P009A, E414, P018A, P020A, P038A or P041A if sole delivery in calendar day, to maximum of 25 sole delivery premiums per physician per 12-month period.

E411	- sole delivery premium add 100%	

OBSTETRICS

LABOUR - DELIVERY

High risk obstetrical premium

Payable in addition to labour and delivery procedures when at least one of the following conditions are present: fetal prematurity (<32 weeks gestational age), severe pregnancy induced hypertension, intrauterine growth retardation (IUGR) less than 10th percentile, or significant placental insufficiency as demonstrated by absent umbilical vessel flow or reverse systolic/diastolic (S/D) ratio.

		Asst	Surg	Anae
# E414	High risk obstetrical premium........................ add		62.05	
# P028	Repair of tear or extension of episiotomy to include rectal mucosa, perianal sphincter and perineum		82.15	6
# Z774	Postpartum haemorrhage - exploration of vagina and cervix, uterine curettage..............................		93.80	6
P007	Postnatal care in hospital and/or home		55.15	
P008	Postnatal care in office		31.45	

REFERRED SERVICES - WHEN ONLY SERVICE(S) RENDERED

Repair of laceration

		Asst	Surg	Anae
# P036	- vaginal		54.40	6
# P039	- cervical...		54.40	6
# P029	Manual removal of retained placenta.....................		54.40	6

OBSTETRICS

OBSTETRICAL ANAESTHESIA

		Asst	Surg	Anae
# P013	Obstetrical anaesthesia		-	6
	Continuous conduction anaesthesia - see General Preamble GP56			
# P014	(a) introduction of catheter for analgesia including first dose		-	6
# P015	(b) maintenance and/or supervision (one unit for each ½ hour to a maximum of 6 units)		-	
# P016	(c) maintenance of obstetrical epidural anaesthesia (one unit for each ½ hour to a maximum of 12)		-	
# E100C	(d) attendance at delivery - per ¼ hour - time units		-	

Note:
When P015 and P016 are claimed same patient same hospital same day, the amount payable for P015 is nil.

		Asst	Surg	Anae
G224	Pudendal, brachial plexus block (bilateral) - (see General Preamble GP58)		15.55	

OBSTETRICS

HIGH RISK PREGNANCIES

		Asst	Surg	Anae
# Z776	Fetal blood sampling		40.80	
# Z773	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis or cordocentesis)		165.40	
# Z734	Double set up examination to rule out placenta previa, or trial of forceps - failed leading to caesarean section (same physician)		58.00	
# P030	Cervical ripening using topical, oral or mechanical agents, maximum once per pregnancy. Payable in conjunction with P022 and P023		58.60	

Note:
Cervical ripening rendered to same patient same day by same physician as a consultation or visit is an insured service payable at nil.

		Asst	Surg	Anae
# P022	Oxytocin infusion for induction of labour - see Obstetrics Preamble paragraph 9		67.75	
# P023	Oxytocin infusion for stimulation of desultory labour		67.75	

Non stress test

Payable only for high risk pregnancies - must include interpretation of trace, discussion with patient and providing a written report to be retained in the patient's permanent medical record and may include application of the fetal monitor and data acquisition. Maximum one per patient per day.

		Asst	Surg	Anae
# P025	Non stress test		9.65	
# Z721	Pharmacological suppression of premature labour by I.V. therapy to be claimed once per physician after 3 hours of supervision in same institution		67.75	
# Z775	Pharmacological management of P.I.H. and toxemia by I.V therapy to be billed once per patient, per pregnancy		67.75	
# Z778	Amniocentesis - diagnostic or genetic		102.00	
# Z779	Chorionic villus sampling		153.00	
# P031	Suture of incompetent cervix in pregnancy cervical cerclage - any technique	5	145.10	6
UVC	Elective removal of Shirodkar suture		visit.fee	
# P034	Uterine inversion, manual replacements		125.75	6
# Z777	Breech presentation - external cephalic version with or without tocolysis - to be claimed in hospital after 35 weeks, once per pregnancy		60.35	

Note:
Listings for ectopic pregnancy, hysterotomy, abortion and postpartum tubal interruption are listed under the Female Genital System - Corpus Uteri.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

INCISION

Abscess or haematoma - Local anaesthetic

Code	Description	Asst	Surg	Anae
	- subcutaneous			
Z101	- one	nil	20.10	
Z173	- two		30.35	
Z174	- three or more		40.80	
Z104	- perianal		20.10	
Z106	- ischiorectal or pilonidal		44.35	
Z103	- palmar or plantar spaces		44.35	
E542	- when performed outside hospital add		11.15	

Abscess or haematoma - General anaesthetic

Code	Description	Asst	Surg	Anae
	- subcutaneous			
# Z102	- one		44.35	6
# Z172	- two or more		66.60	6
# Z105	- perianal		44.35	6
# Z107	- ischiorectal or pilonidal		72.00	6
# Z108	- palmar or plantar spaces		72.00	6

Foreign body removal

Code	Description	Asst	Surg	Anae
Z114	- local anaesthetic		18.80	
E542	- when performed outside hospital add		11.15	
# Z115	- general anaesthetic	5	88.80	6
# Z100	- complicated (see General Preamble GP12)	5	I.C	6
# Z227	Intramuscular abscess or haematoma		101.65	6
Z118	Aspiration of superficial lump for cytology		28.25	

Biopsy(ies)

Code	Description	Asst	Surg	Anae
Z116	- any method, when sutures are used		14.70	
E542	- when performed outside hospital add		11.15	
Z113	- any method, when sutures are not used		14.70	

Note:
Z116 may be allowed more than once on an IC basis if medically necessary (in order to make a diagnosis or to plan treatment) to biopsy more than one lesion or to obtain a second biopsy from an extensive lesion. If claimed, may be allowed with chemical treatment of lesion (code Z117).

Code	Description	Asst	Surg	Anae
# Z155	Biopsy(ies) - extensive, complicated or requiring general anaesthetic when sole procedure (see General Preamble GP12)		I.C	I.C
# Z245	Biopsy for malignant hyperthermia, three or more		152.85	10

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

EXCISION (WITH OR WITHOUT BIOPSY)

LESIONS - SINGLE OR MULTIPLE SITES

Note:

1. Tattoo removal - (see Appendix D Surface Pathology Section 3).
2. Removal of any lesions (e.g. keratosis, nevi) for cosmetic purposes and not for any clinical suspicion of disease or malignancy is not an insured service.

Group 1 - verruca, keratosis, pyogenic granuloma

(see Appendix D Surface Pathology)

		Asst	Surg	Anae
	Removal by excision and suture			
Z156	- single lesion		14.80	6
Z157	- two lesions		22.15	6
Z158	- three or more lesions		36.90	6
E542	- when performed outside hospital ... add		11.15	
	Removal by electrocoagulation and/or curetting			
Z159	- single lesion		10.55	6
Z160	- two lesions		15.85	6
Z161	- three or more lesions		26.20	6

Group 2 - nevus

(see Appendix D Surface Pathology, Section 4)

		Asst	Surg	Anae
	Removal by excision and suture			
Z162	- single lesion		14.80	6
Z163	- two lesions		22.15	6
Z164	- three or more lesions		36.90	6
E542	- when performed outside hospital ... add		11.15	
# Z165	Congenital (extensive) (see General Preamble GP12)		I.C	I.C

Group 3 - plantar verruca

		Asst	Surg	Anae
	Removal by electrocoagulation and/or curetting			
Z169	- single lesion		20.10	6
Z170	- two lesions		30.30	6
Z171	- three or more lesions		59.95	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	Group 4 - cyst, haemangioma, lipoma			
	Face or neck - Local anaesthetic			
Z122	- single lesion	nil	32.20	
Z123	- two lesions		47.60	
Z124	- three or more lesions		65.35	
E542	- when performed outside hospital add		11.15	
	Face or neck - General anaesthetic			
# Z145	- single lesion	5	65.35	6
# Z146	- two lesions	5	98.55	6
# Z147	- three or more lesions	5	131.10	6
# Z148	- extensive or massive (see General Preamble GP12)	5	I.C	6
	Other areas - Local anaesthetic			
Z125	- single lesion	nil	27.05	
Z126	- two lesions		38.15	
Z127	- three or more lesions		50.00	
E542	- when performed outside hospital add		11.15	
	Other areas - General anaesthetic			
# Z149	- single lesion	5	50.00	6
# Z150	- two lesions	5	65.55	6
# Z151	- three or more lesions	5	98.55	6
# Z152	- extensive or massive (see General Preamble GP12)	5	I.C	6
	Group 5 - other lesions			
Z096	Lipoma - 5 to 10 cm	5	73.75	6
E542	- when performed outside hospital add		11.15	
# Z097	Lipoma - over 10 cm	5	110.75	6
# R034	Congenital dermoid cyst adult	5	124.40	6
# R043	- infant or child	5	201.10	6
# R042	- midline, e.g. nasal	5	272.80	6
# R037	Giant cell tumour	5	151.85	6
	Pilonidal cyst			
# R035	- simple excision or marsupialization	nil	183.30	6
# R036	- excision and skin shift	5	248.80	6
	Inguinal, perineal or axillary skin and sweat glands for hyperhydrosis and/or hydradenitis			
# R059	- unilateral	5	248.80	6
# R060	- with skin graft(s) or rotation flap(s)	5	377.90	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

MALIGNANT LESIONS INCLUDING BIOPSY OF EACH LESION - SINGLE OR MULTIPLE SITES

The amount payable for any service rendered in respect of a malignant lesion is reduced to nil if the pathologist's report of his or her examination of the tissue specimen is not retained in the patient's record.

Note:
A pre-malignant lesion is not a malignant lesion for the purposes of payment.

Face or neck

		Asst	Surg	Anae
	Simple excision			
R048	- single lesion	5	70.90	6
R049	- two lesions	5	116.50	6
R050	- three or more lesions	5	233.00	6
E542	- when performed outside hospital ... add		11.15	

Other areas

		Asst	Surg	Anae
	Simple excision			
R094	- single lesion	5	58.15	6
R040	- two lesions	5	95.70	6
R041	- three or more lesions	5	191.40	6
E542	- when performed outside hospital ... add		11.15	

Malignant melanoma

		Asst	Surg	Anae
R010	- wide excision in any area and must include > 1 cm margins and layered closure	5	124.10	6
# E540	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees ... add 25%			

Note:
When excision of benign or malignant lesions are corrected by advancement, rotation, transposition, Z-plasty, flap or graft, claim appropriate benefit listed under Repair Section instead of foregoing excision benefits.

Face or neck

		Asst	Surg	Anae
	Curettage, electrodesiccation or cryosurgery			
R018	- single lesion	5	68.55	6
R019	- two lesions	5	112.90	6
R020	- three or more lesions	5	225.75	6

Other areas

		Asst	Surg	Anae
	Curettage, electrodesiccation or cryosurgery			
R031	- single lesion	5	55.05	6
R032	- two lesions	5	90.70	6
R033	- three or more lesions	5	181.55	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
# R051	Laser surgery on Group 1-5 and malignant lesions (see General Preamble GP12)		I.C	I.C

Note:
Physicians treating vascular ectasias by laser may obtain from their Ministry of Health and Long-Term Care Medical Consultant the current Ministry policy regarding conditions approved for coverage under the Plan.

MOHS' SURGERY

Note:

1. R081 and E524 are billable only for complicated epithelial cancer where 2 or more previous treatments have failed or where the cancer is in an anatomical area where tissue preservation is of the utmost importance (e.g. ear, nose, eyelids and mouth).
2. R081 and E524 are billable only once whether or not excision of the lesion extends to the subsequent day.
3. Closure of the resulting defect by undermining and advancement flaps is included in the above fees. If more complicated closure is medically necessary, bill as an extra under appropriate listings for skin grafts.
4. The preparation of slides must be done or supervised by the Mohs' surgeon and all tissue section slides must be personally microscopically reviewed and interpreted personally by the physician claiming Mohs' surgery.
5. Where a physician submits a claim for performing Mohs' surgery to four patients on any one day, the amount payable for any other Mohs' surgery performed by the same physician on the same day is reduced to nil.

		Asst	Surg	Anae
# R081	Initial cut, including debulking		265.45	6
# E524	- one or more additional cuts ... add		233.55	

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

REPAIR

Debridement and dressing

		Asst	Surg	Anae
UVC	- minor		visit fee	
# Z153	- major (not to be claimed in addition to Z176)		14.05	
# Z144	- requiring general anaesthetic	5	56.75	6
# R082	- extensive (see General Preamble GP12)	5	I.C	6

Note:
Not to be claimed in addition to any surgical procedure unless complications require such care in excess of the usual post-operative care.

Burns

Note:
For burn care requiring anaesthetists' and assistants' services, the following fees apply.

		Asst	Surg	Anae
# R030	Minor burns - up to 15%	5	-	6
# R038	Moderate burns - 16% to 30%	6		10
# R039	Major burns - more than 30%	8	-	15

Resuscitation - Major Burn, Initial Care

These fees apply to the service of being in constant or periodic attendance during a 24 hour period following a major burn, to provide all aspects of resuscitation to the patient. This follows the initial assessment, and includes such subsequent assessments as may be indicated. The specific elements are those of an assessment, including ongoing monitoring of the patient's condition, and intervening as appropriate (see General Preamble GP15). Instead of element H, the assessment includes, providing premises, equipment, supplies and personnel for any aspects of the specific elements that is(are) performed in a place other than the place in which the assessment is performed. Separately billable interventions may be claimed in addition to these fees.

		Asst	Surg	Anae
# Z180	- first 24 hours		106.25	
# Z181	- continuing care (up to 3 days), per day		53.10	

Debridement and excision

		Asst	Surg	Anae
# R660	- hand, each digit		28.90	
# R661	- dorsum palm - each		47.95	
# R662	- nose, cheek, lip, ear, forehead, scalp, neck, eyelid - each		28.90	
# R637	Debridement and excision, per % of total body treated other than hand, head or neck		29.65	

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	Grafting of burn, per % of total body treated			
# R638	Other than hand, head or neck		49.25	
	Hand			
# R663	- each digit		57.60	
	Palm, dorsum			
# R664	- each		115.20	
	Nose, lip(s)			
# R665	- each		192.00	
	Cheek(s), forehead			
# R666	- each		192.00	
# R667	Ear		192.00	
# R668	Eyelid		192.00	
	Scalp			
# R669	- less than 10%		96.05	
# R670	- up to 50%		251.55	
# R671	- over 50%		323.60	
	Neck			
# R672	- less than 10%		96.05	
# R673	- up to 50%		241.85	
# R674	- over 50%		313.95	
	Skin allograft procurement			
R690	- for banking purposes, per % of total body harvested, other than hand, head or neck	7	17.25	7

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Suture of lacerations

Note:
Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee.

		Asst	Surg	Anae
Z176	- up to 5 cm		14.80	6
Z154	- up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers		35.90	6
Z175	- 5.1 to 10 cm		35.90	6
Z177	- 5.1 to 10 cm if on face and/or requires tying of bleeders and/or closure in layers		71.30	6
Z179	- 10.1 to 15 cm		50.40	6
Z190	- 10.1 to 15 cm if on face and/or requires tying of bleeders and/or closure in layers		101.45	6
Z191	- more than 15.1 cm - other than face		77.30	6
Z192	- more than 15.1 cm - on face		154.95	6
E530	- if inhalation general anaesthesia (other than 50% N_2O/O_2 mixture) is used, when suture of laceration is sole procedure add		50.40	
E531	- if extensive debridement is required (see General Preamble GP12) add		I.C	
E542	- when performed outside hospital add		11.15	
R024	Acute laceration earlobe, unilateral		100.65	
UVC	Removal of sutures only		visit fee	

Note:
The above benefits include the use of sutures, local anaesthetic, tetanus toxoid and routine observation.

Muscle repair

		Asst	Surg	Anae
# R525	Simple muscle repair(s) to include repair of involved skin	5	88.60	6
# R528	Complex (see General Preamble GP12)	5	I.C	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

PREAMBLE TO SKIN FLAPS AND GRAFTS

The amount payable will depend on the size and location of the area grafted and the type of graft. Additional procedures other than the skin grafting are payable in addition to the skin flap or grafts, e.g. tendon grafts, inlay grafts, etc.

E540 - payable once per lesion for excision of tumour free with frozen section, to first flap or graft procedure . . add 25%

SKIN FLAPS

A. Advancement flaps

Note:
To include undermining of more than 2.5 cm per side. Is intended to include excision of a lesion if this is technique of closure.

		Asst	Surg	Anae
	Defect 2.1 to 5 cm			
# R011	- face, neck or scalp	5	89.85	6
# R002	- other areas	5	67.40	6
	Defect 5.1 to 10 cm			
# R012	- face, neck or scalp	5	247.15	6
# R003	- other areas	5	161.75	6
# R004	Defect more than 10 cm such as thoracic abdominal flap	5	242.70	6

B. Rotations, transpositions, Z-plasties

Note:
Includes undermining but will depend on the site and size.

		Asst	Surg	Anae
	Defect less than 2 cm average diameter			
# R045	- face, neck or scalp	5	199.55	6
# R072	- other areas	5	133.40	6
	Defect 2.1 to 5 cm average diameter			
# R046	- face, neck or scalp	5	335.15	6
# R075	- other areas	5	223.35	6
	Defect 5.1 to 10 cm average diameter			
# R047	- face, neck or scalp	5	477.45	6
# R073	- other areas	5	318.45	6
	Defect more than 10 cm average diameter			
# R076	- face, neck or scalp	5	709.90	6
# R074	- other areas	5	477.85	6

		Asst	Surg	Anae
	C. Pedicle flaps			
# R079	Small, e.g. cross finger	5	133.40	6
# R077	- each subsequent stage	5	98.90	6
# R070	Intermediate, e.g. cervical finger	5	293.75	6
# R071	- each subsequent stage	5	223.35	6
# R080	Large, e.g. cross leg, deltopectoral, forehead	5	416.30	6
# R078	- each subsequent stage	5	311.45	6
# E069	- preparation of a contracted recipient site, to R070 and R080 add		134.75	
# R103	Delay of tube or pedicle		63.15	6
# R101	Delay, intermediate flap	5	132.45	6
# R100	Delay, major flap	5	291.90	6
	D. Myocutaneous, myogenous or fascia-cutaneous flaps			
	Note: To include closure by any means.			
# R005	Sterno-mastoid, tensor fascia lata, gluteus maximus, gracilis, sartorius, rectus femoris, gastrocnemius (medial and lateral), trapezius	5	470.90	6
# R006	Pectoralis major, latissimus dorsi, unilateral rectus abdominus	5	734.95	6
# R008	Lower transverse rectus abdominus flap	6	984.55	8
	Repair of abdominal defect			
# Z195	- same surgeon		201.10	
# Z196	- different surgeon		377.65	
# R009	Myocutaneous - osseous flaps e.g. pectoralis major myocutaneous flap with rib graft, trapezius flap with scapula spine	6	783.40	8
# R007	Other - (see General Preamble GP12)	I.C	I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

SKIN GRAFTS

A. Split thickness grafts (for burn grafts see pages M6 & M7)

		Asst	Surg	Anae
# R084	Very minor, very small areas, e.g. trauma		92.30	6
# R085	Minor, medium sized areas, e.g. small or skin ulcer, breast, etc	5	140.25	6
# R086	Intermediate, large areas, e.g. trunk, arms, legs	5	259.10	6
# R087	Major, complex areas, e.g. face, neck, hands	5	388.00	6
# R088	Extensive major, very large area(s)	5	567.95	6

Note:
The Medical Consultant may be requested to determine appropriateness of code claimed relative to size.

B. Full thickness grafts

		Asst	Surg	Anae
# R092	Minor - less than 1 cm average diameter		93.30	6
# R093	Intermediate - 1 cm to 5 cm average diameter	5	143.10	6
# R083	Major - over 5 cm	5	224.10	6
# R091	Complex - eyelid, nose, lip, face	5	210.20	6

Note:
R092, R093, R083, R091 - The Medical Consultant may be requested to determine appropriateness of codes claimed relative to size of graft.

		Asst	Surg	Anae
# R057	Appendage or tissue re-vascularization involving microanastomosis with or without micro neuroanastomosis (see General Preamble GP12)	I.C	I.C	I.C
# R058	Revision of above (see General Preamble GP12)	I.C	I.C	I.C

Stasis ulcer

		Asst	Surg	Anae
# R847	- with skin graft - per leg	5	195.85	6
# R845	- multiple ligation and skin graft - per leg	5	341.55	6

Neurovascular island transfer

		Asst	Surg	Anae
# R061	Minor, e.g. finger tip	5	140.25	6
# R062	Intermediate, e.g. finger to thumb transfer	5	259.20	6
# R063	Major, e.g. foot to heel	5	430.85	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

FREE ISLAND FLAPS

Note:
When excision of the lesion and preparation of the recipient site are carried out by different surgeons, the preparation fees should be reduced by 15%.

		Asst	Surg	Anae
# R013	Free jejunum artery and vein for transplantation	10	322.70	10
# R014	Preparation of microvascular recipient site for free jejunum artery and vein	10	881.75	10
# R016	Preparation of microvascular recipient site for jejunum artery and vein immediately following ablative surgery, and when recipient vessels are in site of the ablation	10	519.00	10
# R015	Transplantation of free jejunum artery and vein with microvascular anastomosis	10	881.75	10
# R064	Elevation of free island skin and subcutaneous flap and closure of defect	10	832.95	10
# R065	Preparation of microvascular recipient site for free island skin subcutaneous flap	10	881.75	10
# R055	Preparation of microvascular recipient site for free island flap and subcutaneous flap immediately following ablative surgery and when recipient vessels are in site of the ablation	10	519.00	10
# R066	Transplantation of free island skin and subcutaneous flap with microvascular anastomosis(es)	10	881.75	10
# R067	Elevation of innervated free island skin and subcutaneous flap and closure of defect	10	979.25	10
# R068	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap	10	979.25	10
# R056	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap immediately following ablative surgery and when recipient vessels are in the site of ablation	10	576.35	10
# R069	Transplantation of innervated free island skin and subcutaneous flap with microvascular anastomosis(es) and nerve repair	10	915.80	10
# R125	Elevation of free island skin and muscle flap and closure of defect	10	832.95	10
# R126	Preparation of microvascular recipient site for free island skin and muscle flap	10	881.75	10
# R122	Preparation of microvascular recipient site for free island skin and muscle flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	519.00	10
# R127	Transplantation of free island skin and muscle flap with microvascular anastomosis(es)	10	832.95	10

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

FREE ISLAND FLAPS

		Asst	Surg	Anae
# R128	Elevation of free island muscle flap with tendon and nerve, and closure of defect	10	1127.15	10
# R129	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis(es)	10	1126.85	10
# R123	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis(es) immediately following ablative surgery and when recipient vessels are in site of the ablation	10	663.25	10
# R130	Transplantation of free island muscle flap with tendon, nerve and microvascular anastomosis(es)	10	1127.15	10
# R131	Elevation of free island bone flap and closure of defect	10	832.95	10
# R132	Preparation of microvascular recipient site for free island bone flap	10	881.75	10
# R124	Preparation of microvascular recipient site for free island bone flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	519.00	10
# R133	Transplantation of free island bone flap with microvascular anastomosis(es) and bone fixation	10	979.25	10
# R134	Elevation of free island skin and bone flap and closure of defect	10	998.65	10
# R135	Preparation of microvascular recipient site for free island skin and bone flap	10	998.65	10
# R140	Preparation of microvascular recipient site for free island skin and bone flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	587.70	10
# R136	Transplantation of free island skin and bone flap with microvascular anastomosis(es) and bone fixation	10	998.65	10
# R137	Elevation of free toe or finger and closure of defect	10	998.65	10
# R138	Preparation of microvascular recipient site for free toe or finger transplant	10	998.65	10
# R141	Preparation of microvascular recipient site for free toe or finger transplant immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	587.70	10
# R139	Transplantation of free island toe or finger with microvascular anastomosis(es) and tendon nerve and bone repair	10	1175.00	10
# R025	Revision of free island flaps (see General Preamble GP12)	10	I.C	10
# R106	Skin flaps and grafts - other than listed above (see General Preamble GP12)	I.C	I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

FINGER OR TOE-NAIL

		Asst	Surg	Anae
Z110	Extensive debridement of onychogryphotic nail involving removal of multiple laminae		17.45	

Simple, partial or complete, nail plate excision requiring anaesthesia

		Asst	Surg	Anae
Z128	- one		23.80	6
Z129	- multiple		35.70	6
E542	- when performed outside hospital add		11.15	

Radical, including destruction of nail bed

		Asst	Surg	Anae
# Z130	- one	nil	62.75	6
# Z131	- multiple		82.65	6
E542	- when performed outside hospital add		11.15	

Chemical and/or cryotherapy treatment of minor skin lesions

		Asst	Surg	Anae
Z117	- one or more lesions, per treatment		11.05	

Note:
See Appendix D Surface Pathology.

WEBBED FINGERS AND TOES

		Asst	Surg	Anae
# R089	Webbed fingers - one web space	5	269.55	6
# R090	Webbed toes - one web space	5	123.80	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SCAR REVISION - ANY METHOD OF CLOSURE

Code	Description	Asst	Surg	Anae
	Up to 2.5 cm			
R021	- face or neck	5	115.60	6
R026	- other areas	5	77.35	6
	2.6 cm to 5 cm			
R022	- face or neck	5	194.85	6
R027	- other areas	5	130.10	6
	5.1 cm to 10 cm			
R023	- face or neck	5	277.90	6
R028	- other areas	5	185.60	6
	Greater than 10 cm			
R017	- face or neck	5	417.05	6
R029	- other areas	5	288.20	6

Note:

1. Authorization is required for all scar revisions in areas other than the face or neck (see Appendix D).
2. Revision of post-infection scarring of face must be claimed on an "I.C" basis - maximum payable will be as equated to R023.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

PLASTIC SURGERY PROCEDURES

The setting of benefits covering the various procedures of plastic surgery is a very difficult problem. Since many procedures are divided into stages which have to be considered in assessing a fee, it is felt that all such plastic surgical procedures should be classed by the responsible specialist as very minor, intermediate, major or extensive major. Benefits should be claimed according to procedures set forth in the tariff, except in cases which are difficult to define, in which case "I.C" should be the basis of the claim.

The minimum benefit for each would be as follows:

		Asst	Surg	Anae
# R150	Very minor		92.30	6
# R151	Minor	5	140.25	6
# R152	Intermediate	5	259.20	6
# R153	Major	5	388.00	6
# R154	Extensive major	5	568.95	6

Note:

1. Descriptive details of procedure (e.g. operative report) should be submitted with claims for codes R150 - R154 for professional assessment.
2. Taking of skin by a surgeon for grafting by an Oral Surgeon - claim as R150.

		Asst	Surg	Anae
# Z132	Insertion of tissue expander	5	196.70	6
# E527	- additional expander, same incision add		58.95	
# E528	- additional expander, different incision add		167.30	

Note:
Authorization may be required from the Ministry of Health and Long-Term Care (e.g. for scars of legs, etc.).

Removal tissue expander injection port when sole procedure

		Asst	Surg	Anae
# Z094	- general anaesthetic	5	75.45	6
# Z095	- local anaesthetic		37.70	
Z137	Percutaneous inflation of first tissue expander		23.05	
E541	- each additional expander (to a maximum of 3)		11.55	
# Z138	Replacement of tissue expander by permanent prosthesis		195.85	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

OPERATIONS ON THE BREAST

		Asst	Surg	Anae
	INCISION			
	Needle biopsy			
Z141	- one or more	nil	25.15	
E542	- when performed outside hospital add		11.15	
Z143	- large core breast biopsy - (14 gauge or larger bore needle)		107.05	
	Aspiration of cyst			
Z139	- one or more	nil	25.15	
	Drainage of intramammary abscess or haematoma			
# Z140	Single or multiloculated - local anaesthetic		25.15	
# Z740	Single or multiloculated - general anaesthetic		63.05	6
	EXCISION			
# R107	Tumour or tissue for diagnostic biopsy and/or treatment, e.g. carcinoma, fibroadenoma or fibrocystic disease (single or multiple - same breast)	5	137.05	6
# E525	- after mammographic wire localization add		41.55	
# R111	Partial mastectomy or wedge resection for treatment, of breast disease with or without biopsy, e.g. carcinoma or extensive fibrocystic disease	5	269.40	6
# E525	- after mammographic wire localization add		41.55	
# E546	- with axillary node dissection up to the level of the axillary vein add		315.95	2
# E505	- with limited axillary node sampling add		178.05	1
# R105	Partial mastectomy plus radical node dissection	5	658.15	6
# E525	- after mammographic wire localization add		41.55	
	Mastectomy - female (with or without biopsy)			
# R108	- simple	5	273.95	6
# R117	- subcutaneous with nipple preservation	5	273.95	6

Note:
R117 - include skin grafts if required.

		Asst	Surg	Anae
# R109	Mastectomy, radical or modified radical (with or without biopsy)	5	658.15	6

Note:
R109 - allow skin graft in addition if claimed.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

OPERATIONS ON THE BREAST

Mastectomy - Male (benign)

Unilateral - for treatment of adolescent gynecomastia, gynecomastia secondary to endocrine or genetic disorders (e.g. Klinefelter's Syndrome) or chemotherapy. Prior approval is not required. Removal of male breast fat tissue by liposuction is not an insured service.

Code	Description	Asst	Surg	Anae
# R146	- simple	5	177.50	6
# R147	- subcutaneous with nipple preservation	5	273.95	6

Mastectomy - male

Unilateral - for treatment of pathological male breast disease (with or without biopsy), e.g. carcinoma

Code	Description	Asst	Surg	Anae
# R148	- simple	5	273.95	6
# R149	- subcutaneous with nipple preservation	5	273.95	6

REPAIR

Post-mastectomy breast reconstruction

Code	Description	Asst	Surg	Anae
# R119	Breast mound creation by prosthesis and/or soft tissue	5	304.10	6
# R118	Breast skin reconstruction by local flaps or grafts	5	405.60	6
# E529	- with breast mound creation by prosthesis and/or soft tissue add		102.45	
# E526	- with contralateral balancing mastopexy or reduction, to include nipple transplantation add		283.35	
# R114	Revision of breast mound	5	230.30	6

Note:
By myocutaneous flaps - see codes R005 - R009.

Code	Description	Asst	Surg	Anae
# R113	Nipple-areola preservation and tissue-banking	5	117.55	6
# R121	Re-implantation of tissue-banked nipple-areola	5	137.15	6
# R120	Nipple-areola reconstruction by grafts	5	230.30	6
# R110	Reduction mammoplasty (female, to include nipple transplantation or grafting) - unilateral	5	472.15	7
# R112	Augmentation mammoplasty - unilateral	5	200.40	6

Note:
R110 - R112 - Claims for these procedures may require Ministry of Health and Long-Term Care authorization (see Surgical Preamble SP5; also, Appendix D).

Code	Description	Asst	Surg	Anae
# Z142	Removal of breast prosthesis	5	79.10	6

Breast capsulotomy closed

Code	Description	Asst	Surg	Anae
# Z133	- no anaesthetic		12.70	
# Z134	- general anaesthetic	5	79.10	6
# Z135	Open capsulotomy with or without replacement of breast prosthesis	5	195.95	6
# Z182	Breast capsulectomy	5	255.05	6
# R006	Myocutaneous flaps - pectoralis major, latissimus dorsi, unilateral rectus abdominus	5	734.95	6

Note:
Correction of inverted nipple(s) is not an insured service.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

GENERAL FEES

			Asst	Surg	Anae
	BONE/FASCIAL/DERMIS/GRAFTS				
	Autogenous				
# E551	- separate incision	add		86.30	
# E552	- same incision	add		58.45	
# Z279	- different surgeon			193.00	
	Homogenous				
# E553	- bank	add		25.15	
	Allograft				
	- donor	85% of excision fee			
# R200	- cadaver - per long bone, each			144.80	
	FIXATION				
# E547	- methyl methacrylate (not arthroplasty)	add		59.40	
# E555	- rigid external fixation (excluding casts) for closed reduction, to closed reduction fee	add 50%			
# E544	- cast bracing with closed reduction, to closed reduction fee	add 40%			
# E569	- percutaneous pinning, to closed reduction fee	add 50%			
# E590	- rigid external fixation - pseudoarthrosis	add		76.10	
	Removal of internal fixation device				
# R267	- general anaesthetic		5	158.65	6
# R268	- local anaesthetic		5	54.85	6
# R598	Removal of extensive external fixation device under general anaesthetic			48.25	6
	Adjustment of circumferential external fixation				
# Z280	- without general anaesthetic			72.35	
# Z281	- with general anaesthetic			145.70	6
# Z210	Insertion traction pin - excludes fractures and dislocations			33.35	
	WOUND CARE				
E550	- insertion of closed irrigation system during a surgical procedure for post-operative management	add		63.15	
# E556	- extensive debridement of compound fractures or dislocations, to reduction fee	add 50%			2
# Z783	Secondary closure			97.35	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

GENERAL FEES

		Asst	Surg	Anae
# R517	Excision of foreign body		107.70	6
# Z250	Chronic Electrical Stimulation (not to include T.E.N.S.) external or internal		193.00	6

CASTS

Application of plaster casts or corrective splints are not to be claimed if applied at the time of surgery (except for the application of a cast brace) or applied during the first 2 weeks for a fracture or dislocation when a procedural fee is applicable. The subsequent application of plaster casts may be claimed according to the following schedule.

Direct supervision requires the physical presence of the physician in the office in which the cast is applied at the time the cast is applied unless all conditions listed on page GP42 of the General Preamble (Delegated Procedures) are met.

		Asst	Surg	Anae
Z201	Finger		10.25	
E584	- application of plaster cast outside hospital ... add		11.15	
Z202	Hand		14.90	6
E584	- application of plaster cast outside hospital ... add		11.15	
Z203	Arm, forearm or wrist		24.10	6
E584	- application of plaster cast outside hospital ... add		11.15	
Z199	Foot		14.90	6
E584	- application of plaster cast outside hospital ... add		11.15	
# Z213	Below knee, knee splints (Stove pipe, etc.)		24.10	6
# Z211	Whole leg (mid thigh to toes)		28.80	6
Z198	Toes		10.25	6
E584	- application of plaster cast outside hospital ... add		11.15	
# Z205	Head and torso	5	97.35	6
# Z208	Shoulder spica	5	97.35	6
# Z206	Body cast	5	57.50	6
	Hip spica			
# Z207	- unilateral	5	97.35	6
# Z209	- bilateral	5	121.60	6
Z216	Wedging of casts in other than fracture treatment		10.25	
Z200	Application of Unna's paste		14.90	
Z873	Application of cast brace (must include hinge)		67.75	
Z204	Removal of plaster (not associated with fractures or dislocations within 2 weeks of initial treatment)		10.25	

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	AMPUTATION			
# R606	Phalanx		161.45	6
# R608	Metacarpal or metaphalangeal joint		190.20	6
# E583	- each additional add		94.60	
# R610	Trans. metacarpal 2nd or 5th ray		279.35	6
# R611	Hand - all metacarpals	5	289.50	6
# R612	Wrist	5	289.50	6
# R629	Revision of amputated finger tip	5	241.55	6
	ARTHRODESIS			
# R465	Finger-thumb	5	256.15	6
# R466	Wrist	5	389.75	6
	ARTHROPLASTY			
# E564	- revision of arthroplasty add 35%			
	Wrist			
# R437	- interposition	5	374.00	6
# R485	- total	6	426.90	6
# R479	- removal only	5	193.00	6
	Hand - interposition			
# R435	- single	5	254.35	6
# R436	- multiple	5	459.40	6
# R489	Single joint - total	5	290.55	6
# R209	Basal thumb - first carpometacarpal joint	5	363.05	6
# R449	Multiple joints - total maximum (arthrodesis and/or arthroplasties)	5	774.90	6
# R500	Removal only	5	144.80	6
# R236	Carpal replacement	5	322.05	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

ARTHROSCOPY

Code	Description	Asst	Surg	Anae
# E595	- arthroscopy in association with surgery - same surgeon add		63.15	

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

Code	Description	Asst	Surg	Anae
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	6
# R211	Synovial biopsy	5	43.60	
# R212	Removal of loose body, screw	5	192.00	6
# R213	Drilling of defect (includes removal of loose body)	5	251.55	6

Debridement

Code	Description	Asst	Surg	Anae
# R221	- local	5	251.55	6
# R224	- total	5	326.55	6

Synovectomy

Code	Description	Asst	Surg	Anae
# R230	- partial	5	196.60	6
# R232	- total	5	481.70	6
# R233	Pinning of osteochondral fragment	5	251.55	6

ARTHROTOMY

Code	Description	Asst	Surg	Anae
# R409	Finger		168.00	6
# R410	Wrist	5	212.50	6

ASPIRATION/INJECTION

See Diagnostic and Therapeutic Procedures - Injections and Infusions.

BIOPSY

Bone

Code	Description	Asst	Surg	Anae
# Z230	- punch, x-ray control		72.35	6
# Z214	- open biopsy or taking of bone graft by other than operating surgeon	5	144.80	6

Joint

Code	Description	Asst	Surg	Anae
# E563	- via arthroscope add		11.10	
Z221	- needle		49.20	
# R409	- open finger		168.00	6
# R410	- open wrist	5	212.50	6

Soft tissue

Code	Description	Asst	Surg	Anae
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		25.15	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	DECOMPRESSION - DENERVATION			
# N290	Decompression median nerve at wrist (carpal tunnel syndrome)	5	156.50	6
# N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding carpal tunnel nerve)	5	256.15	6
	INCISION AND DRAINAGE			
# R409	Finger joint		168.00	6
# R410	Wrist joint	5	212.50	6
	Phalanx/metacarpal/carpus			
# R219	- incision and drainage	5	182.90	6
# R218	- sequestrectomy	5	144.80	6
# R217	- saucerization and bone graft	5	242.25	6
# R534	Tendon sheath	5	191.85	6
	EXAMINATION/MANIPULATION			
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5)		24.10	6

Note:
Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

EXCISION

	Bone			
# R316	Proximal row carpectomy	5	338.75	6
# R285	Carpal - bone (one)	5	214.45	6
# R317	Dorsal exostosis (triquetrum)	5	189.75	6
# R286	Radial styloid	5	234.75	6
# R283	Phalanx/metacarpal	5	193.00	6
# R272	Bone tumour (see General Preamble GP12)	I.C	I.C	I.C
	Joint			
	Synovectomy/capsulectomy/debridement			
# R425	- finger joint	5	226.40	6
# R414	- two or more joints	5	339.65	6
# R407	Synovectomy of extensor or flexor tendons		224.45	6
# R418	Synovectomy/debridement - wrist	5	342.55	6
# R492	Radio-ulnar meniscectomy	5	231.10	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

			Asst	Surg	Anae
	EXCISION				
	Muscle and Tendon				
	Muscle				
# R522	- simple		5	193.00	6
# R523	- complex		5	484.35	6
	Tendon sheath				
# R550	- single		5	241.60	6
# E572	- each additional	add		200.20	
	Fascia for Dupuytrens				
# R551	- simple or complex with or without flaps or grafts		5	322.15	6
	Ganglion				
# R549	Simple or complex		5	177.80	6
	RECONSTRUCTION				
	Bone - Pseudoarthrosis				
# R321	Phalanx, metacarpal		5	260.75	6
# R322	Scaphoid - must include bone graft and fixation		5	363.80	6

Note:
F019, Z279, and E551 rendered in conjunction with R322 are insured services payable at nil.

	Bone - Deformity				
	Osteotomy - phalanx				
# R257	- terminal			162.65	6
# R258	- middle proximal or metacarpal		5	193.20	6
# E591	- each additional	add		158.65	
	Ligaments				
# R597	Simple/single repair - wrist		5	301.60	6
# R548	Extensive/multiple repair - wrist		5	511.45	6
# R601	Metacarpal phalangeal repair		5	316.75	6

Note:
Reconstruction - Nerve - see page X7

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

RECONSTRUCTION

Tendon

			Asst	Surg	Anae
	Tenoplasty				
# R557	- one		5	223.65	6
# E050	- each additional	add		77.05	
	Tendon graft				
# R559	- one		5	306.30	6
# E052	- each additional	add		259.85	
# R586	Reconstruction of flexor tendon pulley, per finger			97.35	6
	Silicone rod insertion				
# R554	- one		5	294.20	6
# E051	- each additional	add		245.90	
	Transplant/transfer				
# R563	- single		5	284.95	6
# E054	- each additional	add		236.10	
	Tendon repair - extensor				
# R578	- single		5	164.10	6
# E580	- each additional*	add		70.95	
	Flexor				
# R585	- single		5	307.60	6
# E581	- each additional*	add		128.95	
	Mallet finger				
UVC	- closed			visit fee	
# R574	- K-wire			133.95	6
# R573	- open		5	147.20	6
	Boutonniere				
UVC	- closed			visit fee	
# R577	- open		5	147.30	6
# R582	- late		5	246.65	6

Note:
*If additional tendon repair(s) requires a separate incision, bill according to Surgical Preamble SP3.

Extremities

		Asst	Surg	Anae
# R602	Pollicization	6	596.35	6
# R603	Digital reimplantation involving microvascular and neuro anastomosis	8	1586.20	8
# R604	Revision of R602, R603 (see General Preamble GP12)	I.C	I.C	I.C
# R605	Reconstruction and plastic repair of traumatically amputated extremities (see General Preamble GP12)	I.C	I.C	I.C

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

			Asst	Surg	Anae
	RELEASE				
	Tendon				
	Tenolysis - flexor and/or extensor tendon of				
# R575	- one digit		5	194.05	6
# E537	- each additional digit	add		165.20	
# R541	Flexor tenolysis with pulley preservation		5	283.45	6
	Tenotomy or fasciotomy (closed)				
	Finger				
# Z247	- one			49.20	6
# Z248	- two			72.35	6
# Z249	- three or more			99.15	6
# Z231	- palmar or plantar			73.70	6
	Tendon release (open)				
# R536	- finger/palm			106.90	6
# R537	- wrist		5	137.10	6
# E571	- more than one	add		117.00	
	REDUCTION				
	Fractures				
	Phalanx				
F004	- no reduction, rigid immobilization			49.20	
F005	- closed reduction			99.25	6
E584	- application of plaster cast outside hospital	add		11.15	
E558	- each additional	add		22.25	
# F007	- open reduction		5	248.70	6
	Metacarpal				
F008	- no reduction, one or more, rigid immobilization			49.20	
F009	- closed reduction			99.25	6
E584	- application of plaster cast outside hospital	add		11.15	
E504	- each additional	add		22.20	
# F011	- open reduction		5	218.85	6
E559	- each additional (open)	add		142.90	
	Intra-articular				
F006	- closed reduction			119.75	
E584	- application of plaster cast outside hospital	add		11.15	
E503	- each additional	add		26.85	
# F010	- open reduction		5	279.85	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

REDUCTION

		Asst	Surg	Anae
	Fractures			
	Bennett's			
F012	- no reduction, rigid immobilization		49.20	
E584	- application of plaster cast outside hospital .... add		11.15	
# F013	- closed reduction	5	119.80	6
# F015	- open reduction	5	279.85	6
	Carpus			
F102	- no reduction, rigid immobilization		49.20	
E584	- application of plaster cast outside hospital .... add		11.15	
# F016	- closed reduction, one or more		115.10	6
# F017	- open reduction, one or more	5	288.45	6
	Scaphoid			
F018	- no reduction, rigid immobilization		49.20	
E584	- application of plaster cast outside hospital .... add		11.15	
# F019	- open reduction	5	314.95	6
# F020	- excision	5	193.00	6
	Dislocations			
	Finger			
D001	- closed reduction		57.50	6
E584	- application of plaster cast outside hospital .... add		11.15	
E576	- each additional .... add		10.25	
# D003	- open reduction	5	196.50	6
	Metacarpal/phalangeal			
D004	- closed reduction		57.50	6
E584	- application of plaster cast outside hospital .... add		11.15	
E577	- each additional .... add		10.25	
# D006	- open reduction	5	181.85	6
	Carpal			
D007	- closed reduction		128.05	6
E584	- application of plaster cast outside hospital .... add		11.15	
# D008	- open reduction	5	241.30	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

ELBOW AND FOREARM

AMPUTATION

		Asst	Surg	Anae
# R613	Through radius and ulna	5	306.30	6
# R614	Elbow disarticulation	5	289.50	6

ARTHRODESIS

		Asst	Surg	Anae
# R466	Elbow	5	389.75	6

ARTHROPLASTY

		Asst	Surg	Anae
# E564	- revision of elbow arthroplasty add 35%			
# R281	Ulna replacement (lower end)	5	296.90	6
# R288	Implant radial head	5	251.55	6
# R499	Removal of total replacement	5	402.75	7
# R486	Complete arthroplasty replacement	6	619.90	8
# R510	Interposition arthroplasty	6	435.20	7

ARTHROSCOPY

		Asst	Surg	Anae
# E595	- arthroscopy in association with surgery - same surgeon add		63.15	

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

		Asst	Surg	Anae
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	6
# R211	Synovial biopsy	5	43.60	6
# R212	Removal of loose body, screw	5	192.00	6
# R213	Drilling of defect (includes removal of loose body)	5	251.55	6

Debridement

		Asst	Surg	Anae
# R221	- local	5	251.55	6
# R224	- total	5	326.55	6

Synovectomy

		Asst	Surg	Anae
# R230	- partial	5	196.60	6
# R232	- total	5	481.70	6
# R233	Pinning of osteochondral fragment	5	251.55	6

ARTHROTOMY

		Asst	Surg	Anae
# R445	Elbow, loose body, etc.	5	199.55	6

ASPIRATION/INJECTION

See Diagnostic and Therapeutic Procedures - Injections and Infusions.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

ELBOW AND FOREARM

		Asst	Surg	Anae
	BIOPSY			
	Bone			
Z225	- needle		72.35	6
# Z214	- open		144.80	6
	Joint			
# R432	- open	5	171.45	6
# E563	- via arthroscope add		11.10	
# Z228	Muscle/soft tissue		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		25.15	
	DECOMPRESSION/DENERVATION			
# R495	Fasciotomy for compartment syndrome (not including secondary closure wound)	5	320.20	6
# Z783	Secondary closure		97.35	6
	Catheter			
# Z251	- insertion		49.20	
UVC	- monitoring		visit fee	
# N190	Exploration and/or decompression and/or neurolysis of ulnar nerve (elbow)	5	215.35	6
# N189	Ulnar nerve transposition at elbow - may include exploration, decompression and/or neurolysis	5	279.25	6
# R426	Denervation - elbow	5	258.00	6
	INCISION AND DRAINAGE			
# R228	Acute	5	302.55	6
# Z226	Soft tissue or bursa, incision and drainage		97.35	6
# R445	Elbow	5	199.55	6
# R231	Sequestrectomy	5	355.35	6
# R229	Saucerization and bone grafting	5	452.90	6
	EXAMINATION/MANIPULATION			
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5)		24.10	6

Note:
Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

ELBOW AND FOREARM

		Asst	Surg	Anae
	EXCISION			
	Bone			
# R287	Radial head	5	217.95	6
# R286	Radial styloid	5	234.75	6
# R643	Ulna lower end	5	193.00	6
# R290	Olecranon	5	207.90	6
# R291	Olecranon with fascial repair	5	309.00	6
	Bursae			
# R595	Olecranon	5	101.25	6
	Joint Contents			
# R421	Synovectomy/capsulectomy/debridement, etc.	5	311.85	6
	Muscles			
# R524	Myositis ossificans	5	289.50	6
# R517	Foreign body removal		107.70	6
	Tumours			
	Soft tissues			
# R591	- superficial	5	196.05	6
# R592	- deep	5	484.35	6
	Bone tumours			
# R294	- exostosis	5	165.20	6
# R295	- simple excision	5	289.50	6
# R293	- extensive with replacement	5	677.50	6
	RECONSTRUCTION			
	Bone - Pseudoarthrosis			
# R323	Radius or ulna	5	304.40	6
# R473	Radius and ulna	5	411.20	6
# R950	Radius and ulna - circular external fixation	5	291.40	6
	Bone - Deformity			
	Osteotomy			
# R259	- radius or ulna	5	297.85	6
# R324	- radius and/or ulna with reconstruction congenital abnormality, synostosis etc.	5	398.10	6
# R951	Single level correction - circular external fixation	5	638.40	6
# R952	Double level correction - circular external fixation	5	798.10	6
	Bone transport			
# R953	- circular external fixation (less than or equal to 6 cm)	5	655.15	6
# R954	- circular external fixation (greater than 6 cm)	5	763.80	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

ELBOW AND FOREARM

Code	Procedure		Asst	Surg	Anae
	RECONSTRUCTION				
	Fascia				
	Repair fascial defects				
# R476	- small		5	144.80	6
# R478	- large with or without synthetic graft or rotation flap		5	290.55	6
	Ligaments				
# R597	Simple/single repair		5	301.60	6
# R548	Extensive/multiple repair		5	511.45	6
	Tendons				
	Suture extensor tendon				
# R578	- single		5	164.10	6
# E580	- each additional	add		70.95	
	Suture flexor tendon				
# R585	- single		5	307.60	6
# E581	- each additional	add		128.95	
	Tenoplasty				
# R557	- single		5	223.65	6
# E050	- each additional	add		77.05	
	Tenolysis				
# R556	- single		5	202.25	6
# E599	- each additional	add		87.20	
	Transposition/transplantation/transfer				
# R563	- single		5	284.95	6
# E056	- each additional	add		91.90	
# R583	Steindler flexoplasty		5	344.85	6
	RELEASE				
	Muscles and tendons				
# R519	- simple, e.g. tennis elbow		5	136.35	6
# R521	- radical, e.g. muscle slide		5	314.60	6
	REDUCTION				
	Dislocations				
	Elbow joint				
# D009	- closed reduction			84.45	6
# D010	- open reduction - acute		5	252.45	6
# R400	- repair chronic, recurrent		5	379.50	6
	Radial head				
# D012	- closed reduction, pulled elbow			39.00	6
# D011	- open reduction - acute		5	193.00	6
# R540	- open reduction - recurrent		5	227.40	6
# R558	- open reduction - late		5	357.20	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

ELBOW AND FOREARM

REDUCTION

Fractures

		Asst	Surg	Anae
	Epicondyle			
# F029	- no reduction		67.75	
# F037	- closed reduction	5	126.25	6
# F038	- open reduction	5	214.45	6
	Transcondylar/condylar			
# F039	- no reduction		67.75	
# F040	- closed reduction	5	298.35	6
# F045	- closed reduction with traction	5	312.70	6
# F041	- open reduction	5	375.80	6
	Olecranon			
# F034	- no reduction, rigid immobilization		126.25	6
# F035	- closed reduction	5	129.00	6
# F036	- open reduction	5	224.55	6
	Radius and ulnar shaft			
# F024	- no reduction, rigid immobilization		67.75	
# F025	- closed reduction	5	148.50	6
# F026	- open reduction	5	368.40	6
	Radius and ulna - Monteggia			
# F014	- no reduction, rigid immobilization		67.75	
# F022	- closed reduction		144.80	6
# F023	- open reduction of ulna plus closed reduction radial head	5	242.25	6
	Radius or ulna			
F031	- no reduction, rigid immobilization		67.75	
E584	- application of plaster cast outside hospital add		11.15	
# F032	- closed reduction	5	117.85	6
# F033	- open reduction	5	228.35	6
	Radius - distal, e.g. Colles', Smith's, or Barton's fracture			
F027	- no reduction, rigid immobilization		67.75	
E584	- application of plaster cast outside hospital add		11.15	
# F028	- closed reduction, under local or regional anaesthetic		109.45	
# F046	- closed reduction, under general anaesthetic	5	149.35	6
# F030	- open reduction	5	281.15	6
	Osteochondral			
# F021	- open reduction	5	327.00	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

AMPUTATION

		Asst	Surg	Anae
# R617	Forequarter	10	490.95	15
# R616	Shoulder disarticulation	9	373.10	9
# R615	High humerus	5	369.35	6

ARTHRODESIS

		Asst	Surg	Anae
# R467	Shoulder	5	468.65	6

ARTHROPLASTY

		Asst	Surg	Anae
# E564	- revision of prosthesis ... add 35%			
# R438	Humeral prosthesis	5	449.20	6
# R487	Total prosthesis	6	695.10	10
# R240	Revision total arthroplasty shoulder	6	942.95	10
# R498	Removal prosthesis/no replacement	5	397.20	8

ARTHROSCOPY

		Asst	Surg	Anae
# E595	- arthroscopy in association with surgery - same surgeon ... add		63.15	
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	6
# R211	Synovial biopsy	5	43.60	6
# R212	Removal of loose body, screw	5	192.00	6
# R213	Drilling of defect (includes removal of loose body)	5	251.55	6

Debridement

		Asst	Surg	Anae
# R221	- local	5	251.55	6
# R224	- total	5	326.55	6

Synovectomy

		Asst	Surg	Anae
# R230	- partial	5	196.60	6
# R232	- total	5	481.70	6
# R233	Pinning of osteochondral fragment	5	251.55	6

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

ARTHROTOMY

		Asst	Surg	Anae
# R411	Shoulder	5	223.65	6

ASPIRATION/INJECTION

See Diagnostic and Therapeutic Procedures - Injections and Infusions.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	BIOPSY			
	Bone			
Z220	- needle/punch, x-ray control		72.35	6
# Z214	- open	5	144.80	6
	Joint			
# R411	- open	5	223.65	6
# E563	- via arthroscope add		11.10	
# Z228	Soft tissue - open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		25.15	
	INCISION AND DRAINAGE			
# R222	Humerus/clavicle/scapula	5	262.60	6
# Z226	Bursae/soft tissue		97.35	6
# R411	Joint	5	223.65	6
# R225	Sequestrectomy	5	290.55	6
# R223	Saucerization with bone graft	5	387.90	6
	EXAMINATION AND MANIPULATION			
Z223	Manipulation under general anaesthetic (see Surgical Preamble SP5)		49.20	6

Note:
Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

	EXCISION			
	Clavicle or Acromion			
# R298	Simple (includes ligament)	5	211.60	6

Note:
When R298 is rendered in association with R416, R298 is payable at 100% and R416 is payable at 85%.

# R641	Major tumour	5	290.55	6
# R214	Malignant tumour with reconstruction	5	484.35	6
	Humerus			
# R292	Head	5	299.75	6
# R294	Exostosis	5	165.20	6
# R295	Benign tumour	5	289.50	6
# R297	Malignant tumour with reconstruction	5	681.10	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

EXCISION

Joint

		Asst	Surg	Anae
# R422	Synovectomy and debridement	5	425.10	6
# R512	Excision of subacromial bursa (not to be claimed with R416)	5	211.60	6

Muscle/fascia

		Asst	Surg	Anae
# R522	- simple	5	193.00	
# R523	- complex	5	484.35	6
# R416	Rotator cuff exploration - includes acromioplasty, excision of coraco-acromial ligament and subacromial bursa but excludes simple excision of clavicle	5	206.90	6

Note:
When R416 is rendered in association with R298, R416 is payable at 85% and R298 is payable at 100%.

RECONSTRUCTION

Pseudoarthrosis

		Asst	Surg	Anae
# R329	Clavicle	5	269.10	6
# R325	Humerus	5	346.15	6
# R956	Humerus - circular external fixation	5	291.40	6

Deformity

		Asst	Surg	Anae
	Osteotomy			
# R260	- humerus	5	292.35	6
# R298	- clavicle	5	211.60	6
# R235	- glenoid	5	279.35	6
# R957	Single level correction - circular external fixation	5	510.35	6
# R958	Double level correction - circular external fixation	5	638.40	6
	Bone transport			
# R959	- circular external fixation (less than or equal to 6 cm)	5	655.15	6
# R960	- circular external fixation (greater than 6 cm)	5	763.80	6
	Humeral lengthening			
# R961	- circular external fixation (less than or equal to 6 cm)	5	438.00	6
# R962	- circular external fixation (greater than 6 cm)	5	655.15	6

Note:
Reconstruction - Nerves - see Operations on the Nervous System.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	RECONSTRUCTION			
	Muscles/Soft Tissues			
# R527	Muscle transplant - pectoralis major	6	434.25	6
# R353	Scapulopexy congenital elevation	6	385.15	6
# R568	Trapezius/sternomastoid transplant	5	338.65	6
	Tendon repair			
# R589	- biceps	5	227.40	6
	Rotator cuff repair			
# R593	- simple, end-to-end or side-to-side (includes acromioplasty, excision of coraco-acromial ligament)	5	316.40	6
# R594	- complex (includes implantation into bone, and as required, acromioplasty, excision of coraco-acromial ligament, excision of distal clavicle)	5	466.85	6
# E057	- revision/repair following previous rotator cuff surgery, to R594 add 30%			
	RELEASE			
# R521	Muscle/tendon	5	314.60	6
# R526	Sternomastoid	5	296.05	6
	REDUCTION			
	Fractures			
	Tuberosity			
# F047	- no reduction		67.80	
# F048	- closed reduction	5	117.85	6
# F049	- open reduction (without cuff tear)	5	290.55	6
	Neck without dislocation of head			
# F053	- no reduction		67.80	
# F054	- closed reduction		133.60	6
# F055	- open reduction	5	327.55	6
	Neck with dislocation of head			
# F050	- no reduction		67.80	
# F051	- closed reduction	5	183.80	6
# F052	- open reduction	5	385.15	6
	Shaft			
# F042	- no reduction		67.80	
# F043	- closed reduction	5	147.60	6
# F044	- open reduction	5	323.05	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	REDUCTION			
	Fractures			
	Clavicle			
UVC	- no reduction		visit fee	
# F110	- closed reduction with anaesthetic	5	62.20	6
# F118	- open reduction	5	231.10	6
	Scapula			
# F119	- no reduction		67.80	
# F121	- open reduction	5	242.25	6
	Sternum			
# F123	- closed reduction		115.95	
# F124	- open reduction - pleura open (see General Preamble GP12)	9	I.C	13
# F125	- pleura closed (see General Preamble GP12)	5	I.C	6
	Ribs			
UVC	- no reduction		visit fee	
# F131	- pleura closed (see General Preamble GP12)	5	I.C	6
	Dislocations			
	Acromio-clavicular/sterno-clavicular			
# D014	- no reduction		67.80	
# D025	- closed with anaesthetic	5	134.55	6
# D023	- open reduction	5	231.10	6
# R596	- late	5	286.70	6
	Glenohumeral joint			
# D015	- closed reduction without anaesthetic		49.20	
# D016	- closed reduction with anaesthetic		111.40	6
# D017	- open reduction, early	5	323.85	6
# R472	- open reduction, late	5	580.90	7
# R401	- open reduction, recurrent	5	379.50	6
# E058	- revision/repair following previous glenohumeral joint surgery, to R401 add 30%			

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

ARTHROPLASTY

		Asst	Surg	Anae
# R433	Temporomandibular joint - unilateral	5	349.30	6

BIOPSY

Bone

		Asst	Surg	Anae
# Z869	- punch, simple		39.10	6
# Z870	- punch, x-ray control		97.35	6
# Z242	- open	5	193.00	6

INCISION AND DRAINAGE

		Asst	Surg	Anae
# Z234	Mandibular sequestrectomy	7	281.25	7

EXCISION

		Asst	Surg	Anae
# R272	Bone - tumour (see General Preamble GP12)	I.C	I.C	I.C
# R278	Maxilla, with exenteration of orbit and skin graft	5	532.95	7
# R279	Maxilla advancement	5	440.15	8
# R280	Mandible	5	353.10	7
# R284	Mandibular condyle	5	276.55	6
# R428	Temporomandibular meniscectomy	5	249.75	6

RECONSTRUCTION

Facial paralysis

		Asst	Surg	Anae
# R531	- static slings	5	307.15	6
# R532	- dynamic slings	5	399.00	6
# R533	Composite repair for facial paralysis, plication of paralyzed muscles, and resection for paralysis of over active muscles	5	511.90	7
# E597	- with meloplasty add		87.05	

Note:
Claims for R533 will be assessed by the Medical Consultant.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

ORTHOGNATHIC SURGERY

		Asst	Surg	Anae
	Anterior dento-alveolar osteotomy, maxilla or mandible			
# R382	- one segment	6	803.80	10
# R383	- two segments	6	932.10	10
	Posterior dento-alveolar osteotomy, maxilla			
# R349	- one side	6	803.80	10
# R351	- both sides, single segment	6	932.10	10
# R385	- both sides, separate segments	6	1187.50	10
	Posterior dento-alveolar osteotomy, mandible			
# R462	- one side	6	803.80	10
# R463	- both sides	6	1187.50	10
	Total U dento-alveolar osteotomy			
# R502	- mandible	6	1228.70	10
# R507	- maxilla	6	1315.70	10
# R511	Mandibular or maxillary visor osteotomy for alveolar hypoplasia	6	1146.40	10
	Genioplasty			
# R386	- one segment	6	256.40	10
# R387	- two segments, or for laterognathia	6	383.65	10
# R388	- three segments	6	511.90	10
	Mandibular osteotomies for prognathism			
# R480	- subcondylar	5	420.10	6
# R384	- vertical ramus	6	932.10	10
# R518	- sagittal split	6	932.10	10
	Mandibular osteotomies for retrognathia, any technique			
# R520	- advancement - up to 10 mm	6	932.10	10
# R529	- advancement - 10 to 20 mm, inclusive	6	1058.40	10
# R535	- advancement - greater than 20 mm	6	1356.90	10
# E588	- for apertognathia or laterognathia ... add		256.40	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

ORTHOGNATHIC SURGERY

LeFort I advancement

			Asst	Surg	Anae
# R379	- in one segment		10	803.80	20
# E961	- in two segments	add		296.60	
# E962	- in three segments	add		594.20	

LeFort I intrusion

			Asst	Surg	Anae
# R538	- in one segment		10	1059.35	20
# E963	- in two segments	add		296.60	
# E964	- in three segment	add		594.20	

LeFort I extrusion

			Asst	Surg	Anae
# R567	- in one segment*		10	1315.70	20
# E965	- in two segments	add		296.60	
# E966	- in three segments	add		594.20	

LeFort I cleft palate

			Asst	Surg	Anae
# R580	- in one segment*		10	1525.30	20
# E967	- in two segments	add		256.40	
# E968	- in three segments	add		511.90	
# E969	- with SMR	add		204.80	
# E970	- with pharyngoplasty	add		307.15	
# E971	- with closure alveolar fistula with or without bone graft	add		383.65	
# E972	- with closure hard palate fistula with or without bone graft	add		511.90	

		Asst	Surg	Anae
# R588	Naso-maxillary osteotomy without LeFort I*	6	803.80	10
# R389	LeFort II maxillary osteotomy and advancement*	10	1443.95	20
# R395	Construction glenoid fossa and zygomatic arch* (Obwegeser technique)	10	1402.75	20
# R396	Construction absent condyle and ascending ramus*	6	803.80	10
# R609	Combined LeFort I and LeFort III osteotomy in hemifacial microsomia	10	1586.20	20
# R145	Mandibular condylotomy	5	204.80	6
# R618	Coronoidotomy	5	204.80	6
# R644	Coronoidectomy	5	307.15	6

Note:

* Includes harvesting and grafting of bone or cartilage grafts.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

ORTHOGNATHIC SURGERY

Reconstruction mandible with bone grafts* and/or plate or prosthesis.

		Asst	Surg	Anae
	Unilateral			
# R334	- partial	5	409.55	10
# R335	- complete	5	819.15	10
	Bilateral			
# R645	- partial	5	819.15	10
# R646	- complete	5	1023.95	10

Oral vestibuloplasty

		Asst	Surg	Anae
# R647	- with secondary epithelization	5	204.80	6
# R648	- with skin graft	5	307.15	6

Temporomandibular ankylosis

		Asst	Surg	Anae
# R649	- excision bone or fibrous block	5	461.30	6
# R650	- with insertion of prosthetic device or muscle flap	5	511.90	8
# R651	- with construction of condyle and ascending ramus*	5	666.00	10

Onlay bone grafts to face when not part of standard osteotomy for reconstruction

		Asst	Surg	Anae
	Mandible			
# Z253	- unilateral		358.90	
# Z254	- bilateral		461.30	
	Maxilla			
# Z255	- unilateral		358.90	
# Z256	- bilateral		461.30	
	Zygoma			
# Z257	- unilateral		307.15	
# Z258	- bilateral		409.55	
	Temporal			
# Z259	- unilateral		409.55	
# Z260	- bilateral		511.90	
	Frontal			
# Z261	- unilateral		409.55	
# Z262	- bilateral		511.90	

Application of dental arch bars, or splint, for facial osteotomy

		Asst	Surg	Anae
# Z239	- one arch bar	5	133.00	6
# Z240	- two arch bars	5	204.80	6
# R254	Interdental wiring for temporomandibular joint disorder	5	154.00	6
# R652	Removal intermaxillary fixation devices under general anaesthesia - as sole procedure		102.35	6

Note:

* Includes harvesting and grafting of bone or cartilage grafts.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

ORBITO-CRANIAL SURGERY

			Asst	Surg	Anae
	Bilateral periorbital correction Treacher-Collins Syndrome				
# R390	- with or without bone grafts* (extra-cranial)		10	1699.45	20
# R653	- with skull and muscle transpositions* (includes skull reconstruction) (intracranial)		10	2196.35	25
	Pericranial flap to orbit or face				
# R654	- unilateral			307.15	6
E973	- when in conjunction with coronal approach for main operation	add		178.90	
# R655	- bilateral			409.55	6
# E974	- when in conjunction with coronal approach for main operation	add		297.55	
# R378	LeFort III total maxillary advancement*		12	2037.35	25
# R656	LeFort III and subcranial hypertelorism correction*		12	2590.35	25
# R657	LeFort III and LeFort I maxillary advancement*		12	2334.85	25
# R658	LeFort II, subcranial hypertelorism correction Le Fort I maxillary advancement*		12	2928.10	25
	Upper LeFort III advancement without occlusal change*				
# R659	- unilateral		6	932.10	10
# R675	- bilateral		12	1443.95	25
	Forehead advancement (bone grafts not included)				
# R676	- unilateral		12	1187.50	25
# R393	- bilateral		12	1443.95	25
# R394	Cranial vault reshaping* - anterior or posterior half		10	1525.30	20
# R677	Total cranial vault reshaping*		12	2078.35	25
	Medial transnasal canthopexy				
# R398	- unilateral		5	414.30	6
# E557	- when done in conjunction with another procedure	add		154.00	

Note:
* Includes harvesting and grafting of bone or cartilage grafts.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

REDUCTION

Fractures

			Asst	Surg	Anae
	Orbit - open reduction rim/wall fracture				
# E173	Zygomatic fracture dislocation		5	276.55	6
# E933	- with miniplate(s)**, per major fracture line	add		69.05	
# E934	- with primary bone graft (separate site)	add		204.80	
	Orbit				
# E174	- blowout fracture of floor		5	322.45	6
# E934	- with primary bone graft (separate site)	add		204.80	
	Nasal bones - to include manipulation of nasal septum				
# F136	- closed reduction			102.35	6
# F137	- open reduction***			256.40	6
# E825	- with miniplate(s)**, per major fracture line	add		63.95	
	Orbit with maxilla				
# F150	- closed reduction and dental wiring			256.40	6
# F142	- with wiring and local fixation		5	394.25	6
# E830	- with miniplate(s)**, per major fracture line	add		98.55	
# E932	- unilateral	add		205.00	
# E935	- bilateral	add		307.70	

Note:
E932, E934, and E935 are not to be billed with Z263, Z264, Z265, Z266, E975, or E976.

			Asst	Surg	Anae
	Midface fractures				
	- application of craniofacial suspension wires and external fixation devices (not to be billed in addition to maxillary repair).				
# F143	- middle ¼ facial		5	429.60	8
# E830	- with mini-plate(s)**, per major fracture line	add		98.55	
# F144	- cranial-facial separation		6	542.60	10
# E830	- with mini-plate(s)**, per major fracture line	add		98.55	
	Mandible				
# F138	- closed reduction (including wiring of teeth)		5	256.40	6
# F139	- open reduction (may include wiring of teeth) one side		5	342.55	6
# E828	- with miniplate(s)**, per major fracture line	add		85.70	
# F146	- complicated (see General Preamble GP12)		I.C	I.C	I.C

Note:

1. ** Where mini-plate(s) are used, one mini-plate fee per each major fracture line (e.g. infraorbital, malar-zygomatic, nasal-frontal, LeFort I, LeFort II and III) (per major fracture line per side) should be billed.
2. *** If a full septoplasty is performed, claim in addition the septoplasty codes at 50%. See listings under Nose - Reconstruction.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

REDUCTION

Dislocations

		Asst	Surg	Anae
	Temporomandibular joint			
# D062	- closed reduction		51.65	6
# D063	- open reduction	5	256.40	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PELVIS AND HIP

		Asst	Surg	Anae
	AMPUTATION			
# R631	Hemipelvectomy - hindquarter	10	796.20	15
# R630	Hip disarticulation	10	449.20	10
	ARTHRODESIS			
# R469	Sacro-iliac joint	5	395.25	6
# R514	Symphysis pubis	5	387.00	6
# R470	Hip	5	703.45	8
	ARTHROPLASTY			
# R439	Unipolar	6	490.95	8
# R440	Total hip replacement - acetabulum and femur	8	696.00	8
# R553	Total hip replacement with take down of fusion	8	972.90	10
	Revision total arthroplasty hip - one or both components			
# R241	- acetabular or femoral	8	1304.80	10
# E589	- bone graft to acetabulum add		101.25	
# E593	- acetabular reconstruction (extensive, including bone grafts) add		194.00	
# R481	Reattachment of greater trochanter (late)	6	290.55	8
	Removal only			
# R443	- non-cemented	5	447.30	8
# R488	- cemented	5	557.75	8
# R491	Replacement acetabular liner and/or femoral head	8	353.25	8
	ARTHROSCOPY			
# E595	- preceding surgery - same surgeon add		63.15	
	Hip joint			
# Z218	- sole procedure		97.35	6

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

		Asst	Surg	Anae
	ARTHROTOMY			
# R547	Sacro-iliac joint	5	290.55	6
# R415	Hip - with removal of loose body	5	301.60	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PELVIS AND HIP

ASPIRATION/INJECTION

See Diagnostic and Therapeutic Procedures - Injections and Infusions

		Asst	Surg	Anae
# Z290	Hip - infant or child, under general anaesthesia	5	63.95	6

BIOPSY

Bone

		Asst	Surg	Anae
Z212	- punch needle		72.35	
# Z217	- under general anaesthetic		72.35	6
# Z214	- open		144.80	6

Joint

		Asst	Surg	Anae
# R415	- open	5	301.60	6
# E563	- via arthroscope add		11.10	

Soft tissue

		Asst	Surg	Anae
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		25.15	

DENERVATION/DECOMPRESSION

Exploration, decompression, division, excision, biopsy, neurolysis and/or transposition

		Asst	Surg	Anae
# N188	- minor nerve - including digital, cutaneous or lateral femoral cutaneous nerve	5	153.70	6
# N285	- major nerve - excluding carpal tunnel or ulnar nerve at elbow	5	256.15	6
# N177	Sciatic nerve in buttock	6	430.75	
R427	Denervation of hip	5	387.00	6

Note:
N188 or N285 when performed through the same incision as flexor tendon repairs R585 or E581 is an insured service payable at nil.

INCISION AND DRAINAGE

		Asst	Surg	Anae
# R269	Bone	5	290.55	6
# Z226	Bursae/soft tissue		97.35	6
# R415	Joint	5	301.60	6
# R249	Sequestrectomy	5	379.50	6
# R250	Saucerization and bone graft	5	627.30	6

EXAMINATION/MANIPULATION

		Asst	Surg	Anae
Z252	Manipulation - under general anaesthetic		39.00	6

Note:
Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PELVIS AND HIP

		Asst	Surg	Anae
	EXCISION			
	Bone			
# R639	Simple cyst, etc.	5	338.75	6
# R330	Major resection tumour	5	629.65	6
# R216	Radical resection tumour	8	1007.35	8
# F115	Coccyx	5	208.80	6
# R315	Head and neck, femur	5	452.90	6
	Muscle			
# R522	- simple	5	193.00	6
# R523	- complex	5	484.35	6
# R524	- myositis	5	289.50	6
	Joint			
# R423	Synovectomy/debridement	5	470.50	6
	Bursae			
# R590	GT trochanteric/ischial	5	201.40	6
	RECONSTRUCTION			
	Pseudoarthrosis			
# R364	Pelvis	8	580.90	10
# R328	Hip	6	477.90	6
	Osteotomy			
	Pelvis			
# R265	- infant	8	399.00	8
# R273	- other	8	580.90	8
# R263	Hip	5	539.15	7
	Muscle/Tendon			
# R521	Muscle release	5	314.60	6
	Tenotomy			
# Z232	- closed adductors		49.20	6
# Z233	- open adductors		97.35	6
# R545	- iliopsoas	5	266.35	6
	Tendon Transfer			
# R570	Iliopsoas	5	520.60	6
# R569	Abductor	5	339.65	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PELVIS AND HIP

REDUCTION

Fractures

		Asst	Surg	Anae
	Coccyx			
UVC	- no reduction		visit fee	
# F115	- excision	5	208.80	6
	Pelvic ring			
UVC	- no reduction		visit fee	
# F134	- closed reduction	5	442.45	6
# F135	- open reduction	6	680.30	8
	Sacrum			
UVC	- no reduction		visit fee	
	Femoral neck trochanteric, subtrochanteric			
UVC	- no reduction		visit fee	
# F098	- closed reduction/traction	5	426.90	6
# F099	- open reduction - pin only	6	408.30	8
# F100	- open reduction - pin and plate/screws (cannulated included)	6	498.95	8
# F101	- open reduction - primary prosthesis, femur only (includes Moore, Thompson, Unipolar, Bipolar)	6	490.95	8
# R600	- delayed/staged graft	6	289.50	8
	Slipped epiphysis			
# R607	- closed reduction/traction	6	387.00	8
# R642	- closed reduction/internal fixation	6	387.00	8
# R627	- open reduction/fixation	6	580.90	8

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PELVIS AND HIP

REDUCTION

Dislocations

		Asst	Surg	Anae
	Acetabulum			
UVC	- no reduction		visit.fee	
# D052	- open reduction - lips	7	612.45	8
# D046	- open reduction - one pillar	5	967.90	10
# D047	- open reduction - two pillars	8	1451.45	12
	Hip			
# D042	- closed reduction		268.25	6
# D043	- open reduction	7	406.45	7
# R628	- late, after four weeks - open	7	774.90	10

Note:
May not be claimed with D042 at the same time.

		Asst	Surg	Anae
	Sacro-iliac			
# D059	- closed, traction, spica, etc.		428.50	6
# D060	- open reduction	5	593.00	6
	Sacro-coccygeal			
UVC	- closed reduction		visit.fee	
# D061	- open, removal of coccyx	5	193.00	6
	Congenital hip			
# R404	- closed reduction (includes tenotomy and cast)		190.20	6
# R405	- repeat (includes cast)		131.80	6
# R406	- open reduction (includes tenotomy and arthrotomy)	7	472.35	7
Z291	Application Pavlik Harness or C.D.H. Splint		24.10	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FEMUR

Code	Procedure	Asst	Surg	Anae
	AMPUTATION			
# R625	Gritti-Stokes or Callander	5	305.25	6
# R626	Through femur	5	306.30	6
	BIOPSY			
	Bone			
# Z869	- core, punch		39.10	6
# Z870	- x-ray control/general anaesthetic		97.35	6
# Z242	- open	5	193.00	6
	Soft tissue			
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		25.15	
# R256	Injection into bone cysts		117.00	
	INCISION AND DRAINAGE			
# R242	Bone	5	325.75	6
# R245	Sequestrectomy	5	395.25	6
# R243	Saucerization and graft	5	619.90	6
# Z226	Soft tissue		97.35	6
	EXCISION			
	Bone			
# R314	Simple cyst/exostosis	5	225.50	6
	Bone tumour			
# R330	- simple	5	629.65	6
# R216	- with reconstruction/graft	8	1007.35	8
	Muscle			
# R522	- simple	5	193.00	6
# R523	- complex	5	484.35	6
	RECONSTRUCTION			
	Fascial			
# R632	- simple	5	193.00	6
# R633	- complex with or without synthetic graft or rotation flap	5	402.75	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FEMUR

RECONSTRUCTION

Pseudoarthrosis

Code	Description		Asst	Surg	Anae
# E048	- intramedullary nail with distal and proximal locking screws - femur	add		108.75	
# R328	Bone graft with or without external fixation		6	477.90	6
# R967	Circular external fixation		6	291.40	6

Deformity

Code	Description		Asst	Surg	Anae
# R262	Osteotomy femoral shaft		5	532.65	6
# R215	Osteotomy supracondylar		5	387.00	6
# R963	Single level correction - circular external fixation		5	638.40	6
# R964	Double level correction - circular external fixation		5	798.10	6
# R965	Bone transport - circular external fixation (less than or equal to 6 cm)		5	655.15	6
# R966	Bone transport - circular external fixation (greater than 6 cm)		5	763.80	6

Leg Length Discrepancy

Code	Description		Asst	Surg	Anae
# R333	Femoral shortening		5	480.70	6
# R332	Femoral lengthening		5	541.95	6
# R968	Lengthening with circular external fixation (less than or equal to 6 cm)		5	546.55	6
# R969	Lengthening with circular external fixation (greater than 6 cm)		5	763.80	6
# R340	Femoral epiphysiodesis		5	301.60	6
# R341	Tibial and femoral epiphysiodesis		5	426.90	6
# R343	Femoral stapling		5	313.65	6
# R344	Tibial and femoral stapling		5	387.00	6

Muscles/Tendons

Code	Description		Asst	Surg	Anae
	Quadriceps repair				
# R589	- simple		5	227.40	6
# R587	- reconstructive		5	387.00	6
# R530	Quadricepsplasty - all types		5	381.40	6
# R561	Ilio-tibial band		5	190.10	6
# Z197	Closed release of ilio-tibial band			49.20	6
	Tenotomy of hamstrings				
# R543	- single		5	168.85	6
# R562	- multiple		5	193.00	6
	Lengthening of hamstrings				
# R557	- single		5	223.65	6
# E050	- each additional	add		77.05	
# R571	Tendon or muscle transfer		5	307.15	6
# E049	- each additional	add		87.20	
# R524	Excision of myositis		5	289.50	6

FEMUR

		Asst	Surg	Anae
	REDUCTION			
	Fractures			
	No reduction			
UVC	- cast and bed rest		visit fee	
	Closed reduction			
F094	- traction - infant or child	5	258.00	6
# F095	- traction - adult or adolescent	5	407.35	6
# F097	- cast	5	258.90	6
# F096	- open reduction	6	493.80	8
	Femoral shaft/supracondylar			
# E048	- intramedullary nail with distal and proximal locking screws - femur add		108.75	

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

KNEE

		Asst	Surg	Anae
	AMPUTATION			
# R625	Through knee - disarticulation	5	305.25	6
	ARTHRODESIS			
# R468	Knee	5	402.75	6
	ARTHROPLASTY			
# E564	- revision of arthroplasty ... add 35%			
# R509	Patellar arthroplasty	5	241.60	6
	Hemiarthroplasty			
# R482	- single component (e.g. MacIntosh)	6	351.70	6
# R483	- double component (e.g. Marmar)	6	447.30	6
# R441	Total replacement/both compartments	8	619.90	8
# R248	Total knee replacement with take down of fusion	8	838.00	8
# R244	Revision total arthroplasty knee	8	838.00	8
# E598	- with associated patellar replacement or patelloplasty ... add		94.60	
# R496	Removal of hemiarthroplasty - without replacement	5	242.25	6
# R497	Removal of total arthroplasty - without replacement	5	368.40	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

KNEE

		Asst	Surg	Anae
	ARTHROSCOPY			
# E595	- arthroscopy in association with surgery - same surgeon . . . . add		63.15	
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	6
# R191	Synovial biopsy	5	43.60	6
# R192	Trimming of plica, tissue, meniscus	5	63.75	6
# R193	Removal of loose body, screw	5	192.00	6
# R194	Resection of plica	5	88.20	6
# R195	Lateral release	5	161.45	6
	Synovectomy			
# R196	- anterior, 1 compartment	5	130.85	6
# R197	- anterior, more than 1 compartment	5	262.60	6
# R198	- total, anterior and posterior	5	481.70	6
# R199	Drilling of defect (includes removal of loose body)	5	251.55	6
# R203	Pinning of osteochondral fragment	5	251.55	6
	Debridement			
# R204	- 1 compartment	5	251.55	6
# R205	- more than 1 compartment	5	326.55	6
# R206	Abrasion arthroplasty	5	288.60	6
# R207	Menisectomy	5	240.45	6
# R208	Repair medial or lateral meniscus	5	336.65	6

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

ARTHROTOMY

# R412	Knee - with or without removal of loose body.	5	207.90	6
# R413	Osteochondritis dissecans with drilling and/or internal fixation .	5	267.25	6

ASPIRATION

See Diagnostic and Therapeutic Procedures - Injections or Infusions.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

KNEE

BIOPSY

Bone/joint

		Asst	Surg	Anae
Z870	- needle		97.35	6
# Z242	- open	5	193.00	6
# E563	- via arthroscope add		11.10	

Soft tissue

		Asst	Surg	Anae
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		25.15	

DENERVATION/DECOMPRESSION

		Asst	Surg	Anae
# R426	Denervation of knee	5	258.00	6
# N285	Denervation of gastrocnemius	5	256.15	6

INCISION AND DRAINAGE

		Asst	Surg	Anae
# Z226	Soft tissue		97.35	6
# R444	Joint	5	193.00	6

EXAMINATION/MANIPULATION

		Asst	Surg	Anae
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5)		24.10	6

Note:
Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

EXCISION

		Asst	Surg	Anae
	Baker's cyst			
# R431	- simple	5	148.50	6
# R434	- extensive	5	264.50	6
# R501	Cysts of meniscus	5	126.25	6
# R429	Meniscectomy	5	241.30	6
# R417	Debridement of joint without synovectomy	5	290.55	6
# R424	Synovectomy	5	430.65	6
# R506	Prepatellar bursae	5	149.45	6
# R312	Patella - to include fascial repair	5	276.55	6
# R318	Excision exostosis/cyst patella	5	126.25	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

KNEE

RECONSTRUCTION

Meniscus

		Asst	Surg	Anae
# R508	Suturing of medial or lateral meniscus	5	242.25	6

Muscles/Tendons

		Asst	Surg	Anae
	Tenoplasty			
# R584	- one	5	144.80	6
# E050	- each additional add		77.05	
	Suture of patellar or quadriceps tendon			
# R589	- early	5	227.40	6
# R587	- late	5	387.00	6
	Transplant of tendon			
# R571	- single	5	307.15	6
# E049	- each additional add		87.20	
	Tenotomy			
	- closed			
# Z237	- one		49.20	6
# Z238	- multiple		72.35	6
	- open			
# R564	- one	5	232.00	6
# R566	- multiple	5	253.30	6
# R516	Release patellar retinaculum	5	161.45	6

Ligaments

		Asst	Surg	Anae
# R599	- simple - one	5	361.95	6
# R542	- extensive/multiple (including synthetics)	5	517.85	6
# E059	- revision/repair following previous reconstruction of knee ligaments to R542 add 30%			
# R484	- synthetic anterior/posterior cruciate	6	493.80	6
# R539	- removal of synthetics	5	213.45	6

REDUCTION

Fractures

		Asst	Surg	Anae
	Patella			
# F085	- no reduction		67.75	
# F087	- open reduction or excision with or without repair	5	275.65	6
# F021	Osteochondral fracture - open reduction	5	327.00	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

KNEE

REDUCTION

Dislocations

		Asst	Surg	Anae
	Knee			
# D038	- closed reduction		207.90	6
# D039	- open reduction	5	309.00	6
	Patella			
	- closed reduction			
# D040	- without anaesthetic		62.20	
# D031	- with anaesthetic		97.35	6
	- open reduction			
# D041	- early		290.55	6
# R255	- late	5	484.35	6
# R403	- repair recurrent dislocation (includes inspection of joint).	5	393.40	6
# R515	Congenital dislocation - knee (open)	5	484.35	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FIBULA AND TIBIA

		Asst	Surg	Anae
	AMPUTATION			
# R624	Tibia/fibula	5	306.30	6
	BIOPSY			
	Bone			
# Z870	- simple - punch		97.35	6
# Z242	- open	5	193.00	6
	Soft tissue			
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		25.15	
# R256	Injection into bone cysts		117.00	
	DECOMPRESSION/DENERVATION			
# R495	Decompression of fascial compartments	5	320.20	6
# Z783	Secondary closure		97.35	6
# Z251	Catheter insertion		49.20	
UVC	Monitoring of pressure monitoring device		visit.fee	
# N184	Decompression of posterior tibial or common perineal nerve	5	165.20	6
	INCISION AND DRAINAGE			
# R237	Bone	5	308.10	6
# R239	Sequestrectomy	5	329.40	6
# R238	Saucerization and bone grafting	5	411.20	6
# Z226	Soft tissue		97.35	6
	EXCISION			
# R311	Exostosis/cyst	5	201.40	6
# R210	Fibular head	5	193.00	6
	Tumour			
# R295	- simple	5	289.50	6
# R253	- extensive with repair	5	648.20	6
# R246	Excision bony ridge to include interpositional materials	5	385.15	6
	Muscle/soft tissue			
# R522	- simple	5	193.00	6
# R523	- complex	5	484.35	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FIBULA AND TIBIA

RECONSTRUCTION

Pseudoarthrosis

		Asst	Surg	Anae
# E041	- intramedullary nail with distal and proximal locking screws - tibia ... add		81.55	
# R326	Tibia/fibula	5	348.00	6
# R327	By-pass fibular graft	5	341.45	6
# R372	Congenital pseudoarthrosis	5	484.35	6
# R970	Circumferential external fixation	5	291.40	6

Deformity

		Asst	Surg	Anae
# R289	Osteotomy tibia and fibula - adult or child	5	376.80	6
# R971	Single level correction - circular external fixation	5	510.35	6
# R972	Double level correction - circular external fixation	5	638.40	6
	Bone transport			
# R973	- circular external fixation (less than or equal to 6 cm)	5	634.70	6
# R974	- circular external fixation (greater than 6 cm)	5	763.80	6
# R403	Osteotomy repair recurrent dislocation (includes inspection of the joint)	5	393.40	6

Leg Length Discrepancy

		Asst	Surg	Anae
# R331	Tibial lengthening	5	470.50	6
# R458	Tibial shortening	5	387.00	6
# R341	Tibial and femoral epiphysiodesis	5	426.90	6
# R339	Tibial epiphysiodesis	5	322.05	6
	Tibial stapling			
# R342	- one side	5	193.00	6
# R460	- both sides	5	242.25	6
# R344	Tibial and femoral stapling	5	387.00	6
# R975	Lengthening with circular external fixation (less than or equal to 6 cm)	5	438.00	6
# R976	Lengthening with circular external fixation (greater than 6 cm)	5	655.15	6

REDUCTION

Fractures

		Asst	Surg	Anae
	Tibia with or without fibula			
# F078	- no reduction, rigid immobilization		115.95	
# F079	- closed reduction	5	180.05	6
# F080	- open reduction - shaft	5	356.40	6
	Intramedullary nail with distal and proximal locking screws			
# E041	- tibia ... add		81.55	
# F081	- medial or lateral tibial plateau	5	394.45	6
# E532	- both tibial plateaus, same knee ... add 50%			
	Fibula			
# F082	- no reduction, rigid immobilization		67.75	
# F083	- closed reduction		101.25	6
# F084	- open reduction	5	230.20	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
	AMPUTATION				
# R620	Metatarsal/phalanx disarticulation		5	155.90	6
# E585	- each additional	add		47.30	
# R621	Ray (single)		5	217.15	6
# R623	Symes		5	285.80	6
# R622	Transmetatarsal/transtarsal		5	235.75	6
# R619	Terminal Symes		5	144.80	6
	ARTHRODESIS				
# R466	Ankle		5	389.75	6
# R552	- revision of arthrodesis		5	506.65	6
# R471	Interphalangeal		5	151.85	6
# E575	- each additional	add		41.70	
# R477	Metatarsophalangeal		5	247.25	6
# R474	Midtarsal/subtalar		5	370.85	6
# R513	Triple		5	423.80	6
# R475	Pan-talar, one stage		5	626.45	6
	ARTHROPLASTY				
# E564	- revision of arthroplasty	add 35%			
# R485	Ankle - total replacement		6	426.90	6
# R247	Revision total arthroplasty ankle		6	564.30	6
# R479	Removal of prosthesis without replacement		5	193.00	6
	Metatarsophalyngeal interposition				
# R456	- single		5	144.80	6
# E538	- each additional	add		38.00	
# R453	Metatarsophalyngeal (Swansons, etc.)		5	289.50	6
# R454	- multiple		5	387.00	6
# R500	Removal - prosthesis without replacement		5	144.80	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

ARTHROSCOPY

Code	Procedure	Asst	Surg	Anae
# E595	- in association with surgery - same surgeon		63.15	
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	6
# R211	Synovial biopsy	5	43.60	6
# R212	Removal of loose body, screw	5	192.00	6
# R213	Drilling of defect (includes removal of loose body)	5	251.55	6

Debridement

Code	Procedure	Asst	Surg	Anae
# R221	- local	5	251.55	6
# R224	- total	5	326.55	6

Synovectomy

Code	Procedure	Asst	Surg	Anae
# R230	- partial	5	196.60	6
# R232	- total	5	481.70	6
# R233	Pinning of osteochondral fragment	5	251.55	6

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

ARTHROTOMY

Ankle

Code	Procedure	Asst	Surg	Anae
# R503	- removal of loose body, etc.	5	167.10	6
# E539	- with osteotomy of malleolus add		117.85	
# R504	Midtarsals	5	144.80	6
# R505	Metatarsal/phalangeal	5	144.80	6

ASPIRATION

See Diagnostic and Therapeutic Procedure - Injections or Infusions.

BIOPSY

Bone

Needle

Code	Procedure	Asst	Surg	Anae
Z869	- punch		39.10	6
# Z870	- under general anaesthetic		97.35	6
# Z242	- open	5	193.00	6

Joint

Code	Procedure	Asst	Surg	Anae
# R409	- open		168.00	6
# E563	- via arthroscope add		11.10	

Soft tissue

Code	Procedure	Asst	Surg	Anae
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		25.15	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

INCISION AND DRAINAGE

		Asst	Surg	Anae
# R220	Bone	5	227.40	6
# Z226	Bursae		97.35	6
# R503	Joints	5	167.10	6
# Z228	Soft tissue - open		97.35	6
# R201	Sequestrectomy	5	193.00	6
# R202	Saucerization and bone graft	5	387.00	6

EXAMINATION/MANIPULATION

		Asst	Surg	Anae
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5)		24.10	6

Note:
Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine

Club foot, etc. - manipulation and cast/strapping

		Asst	Surg	Anae
Z235	- without anaesthetic		19.45	
E584	- application of plaster cast outside hospital add		11.15	
# Z224	- with anaesthetic		39.00	6

EXCISION

Bone

		Asst	Surg	Anae
# R299	Phalanx	5	127.15	6
# R309	Metatarsal head	5	175.45	6
# E587	- each additional add		41.70	
# R305	Accessory navicular (scaphoid)	5	155.90	6
# R302	Bunion/bunionette	5	150.30	6
# R307	Calcaneal spur	5	139.25	6
# R282	Exostosis (dorsal, subungual)	5	100.15	6
# R308	Os calcis, talus	5	283.95	6
# R301	Sesamoid, one or both	5	142.00	6
# R306	Tarsal bar	5	230.20	6
# R266	Tumour (foot)	5	241.30	6

Joint

		Asst	Surg	Anae
# R420	Ankle synovectomy	5	273.75	6
	Metatarsophalangeal synovectomy			
# R425	- one	5	226.40	6
# R414	- two or more	5	339.65	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

Code	Procedure		Asst	Surg	Anae
	EXCISION				
	Soft Tissue				
# R549	Ganglion - simple or complex		5	177.80	6
# R506	Bursa		5	149.45	6
# R551	Fascia for Dupuytrens - partial or complete		5	322.15	6
	Muscle				
# R522	- simple		5	193.00	6
# R523	- complex		5	484.35	6
	RECONSTRUCTION				
	Pseudoarthrosis				
# R363	Malleoli		5	296.05	6
# R321	Tarsals/metatarsals/phalanx		5	260.75	6
	Deformity				
	Osteotomy				
# R259	- os calcis		5	297.85	6
# R276	- metatarsals and phalanx		5	144.80	6
# E596	- each additional	add		41.70	
# R277	- midtarsal/tarsal		5	242.25	6
	Shortening metatarsal				
# R337	- one		5	225.50	6
# R338	- two or more		5	272.80	6
# R977	Circular external fixation without osteotomy*		5	583.75	6
# R978	Circular external fixation with osteotomy*		5	729.45	6
# R979	Circular external fixation with multiple osteotomies*		5	911.30	6

Note:
* This requires the application of tibial apparatus.

Code	Procedure		Asst	Surg	Anae
	Forefoot				
# R430	Claw and hammer toe		5	151.25	6
# E594	- each additional hammer toe	add		41.70	
	Hallux Valgus				
# R304	- e.g. Mayo, Keller		5	217.15	6
# R355	- e.g. Joplin, McBride		5	267.25	6
# R360	Major forefoot reconstruction, must include the first MP joint and a minimum of 2 other MP joints		5	459.45	6
# R446	Overlapping 5th toe		5	136.35	6
	Club Foot				
# R408	Posterior or medial release		5	312.70	6
# R448	Posteromedial release, lateral shortening, tendon transfers and fusion		5	371.20	6
# R313	Complex reconstruction or revision of previous club foot repair (not to include simple tendon releases)		5	468.65	6
# R546	Plantar fascia release (Steindler)		5	165.20	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

RECONSTRUCTION

Ligaments

			Asst	Surg	Anae
	Ankle				
# R597	- one		5	301.60	6
# R548	- extensive/multiple		5	511.45	6

Tendons

			Asst	Surg	Anae
# R640	Exploration - tendon sheath		5	126.25	6
	Tenolysis - extensive release				
# R556	- one		5	202.25	6
# E599	- each additional digit	add		87.20	
	Tendon transfer foot and ankle				
# R565	- single		5	253.30	6
# E055	- each additional	add		94.60	
# R572	Tenodesis		5	258.90	6
# R560	Graft		5	253.30	6
# E053	- each additional	add		94.60	
	Lengthening or shortening				
# R557	- one		5	223.65	6
# E050	- each additional	add		77.05	
	Suture extensor tendon				
# R578	- one		5	164.10	6
# E580	- each additional	add		70.95	
	Suture flexor tendon				
# R585	- one		5	307.60	6
# E581	- each additional	add		128.95	
	Achilles tendon repair				
# R589	- early		5	227.40	6
# R587	- late		5	387.00	6
	Tenotomy - open				
# R579	- one toe			87.20	6
# R581	- more than one toe			193.00	6
	Tenotomy - closed				
# Z229	- one toe			49.20	6
# Z243	- more than one toe			97.35	6
	Achilles or tibialis anterior/posterior tenotomy				
# R544	- open		5	171.70	6
# R555	- closed			132.70	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

REDUCTION

Fractures

		Asst	Surg	Anae
	Ankle			
# F074	- no reduction - rigid immobilization		67.75	
# F075	- closed reduction	5	144.80	6
	- open reduction			
# F076	- one malleolus	5	237.50	6
# F077	- multiple malleoli or ligaments	5	311.85	6
	Ankle fracture with tibial Plafond burst			
# F104	- closed reduction	5	242.25	6
# F108	- open reduction	5	362.95	6
	Metatarsus			
F061	- one or more		49.20	
F062	- with rigid immobilization		67.75	
	- closed reduction			
F063	- one or more	5	98.35	6
E584	- application of plaster cast outside hospital add		11.15	
	- open reduction			
# F064	- one	5	178.20	6
# F065	- two or more	5	249.65	6
	Os calcis			
F070	- no reduction - rigid immobilization		97.35	
F071	- closed reduction		161.45	6
E584	- application of plaster cast outside hospital add		11.15	
	- open reduction			
# F072	- with repair of both the subtalar and calcaneocuboid joints	5	394.15	6
	Phalanx			
F056	- no reduction - rigid immobilization		49.20	
E584	- application of plaster cast outside hospital add		11.15	
E560	- each additional add		12.05	
F058	- closed reduction - one		72.35	6
E584	- application of plaster cast outside hospital add		11.15	
E561	- each additional add		14.90	
# F060	- open reduction	5	172.30	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

FOOT AND ANKLE

		Asst	Surg	Anae
	REDUCTION			
	Fractures			
	Tarsus excluding os calcis			
F066	- no reduction - rigid immobilization		98.10	
F067	- closed reduction	5	165.20	6
E584	- application of plaster cast outside hospital ... add		11.15	
# F068	- open reduction	5	237.50	6
	Intra-articular fracture - I.P. Joint			
F057	- closed reduction		77.95	
E584	- application of plaster cast outside hospital ... add		11.15	
# F059	- open reduction	5	144.80	6
	Dislocations			
	Ankle			
# D035	- closed reduction	5	111.35	6
# D036	- open reduction	5	252.45	6
# R402	- recurrent dislocation and/or subluxation	5	367.45	6
	Interphalangeal			
D027	- closed reduction		57.50	6
E584	- application of plaster cast outside hospital ... add		11.15	
E578	- each additional ... add		10.25	
# D029	- open reduction	5	151.25	6
	Metatarsophalangeal			
D030	- closed reduction		57.50	6
E584	- application of plaster cast outside hospital ... add		11.15	
E579	- each additional ... add		10.25	
# D032	- open reduction	5	163.35	6
	Tarsus			
D033	- closed reduction		147.60	6
E584	- application of plaster cast outside hospital ... add		11.15	
# D034	- open reduction	5	252.45	6

RESPIRATORY SURGICAL PROCEDURES

NOSE

		Asst	Surg	Anae
Z298	Nasopharynx (to include oropharynx, oral cavity and hypopharynx) EUGA of nasopharynx for malignant disease including biopsies (not to be claimed if done in conjunction with T & A, adenoidectomy or quadroscopy)		41.25	6
	Excision of nasopharyngeal or oropharyngeal lesion			
# R181	- with palatal split	5	508.20	7
R182	- with mandibulotomy, glossotomy and/or palatal split	7	987.65	10
Z297	Insertion of prosthesis for nasal septal perforation		18.30	
	ENDOSCOPY			
	Fiberoptic endoscopy of upper airway (nose, hypopharynx or larynx)			
Z296	- with flexible endoscope - if only operative procedure performed		18.30	
Z299	- with rigid endoscope for diagnostic evaluation or to facilitate biopsy or surgical treatment of pathology in the posterior nasal cavity, hypopharynx or larynx		8.55	
# Z317	Examination under anaesthesia (EUA) of nose including suction cautery for posterior epistaxis unilateral or bilateral		112.05	6
# Z306	Excision of middle turbinate concha bullosa - unilateral		55.60	6
	INCISION			
# Z301	Drainage of abscess or haematoma		55.60	6
# Z302	Turbinate reduction - uni- or bilateral (to include cautery, cryosurgery, turbinectomy)		55.60	6
	EXCISION			
	Nasal polyp			
Z304	- single		21.00	
# Z305	- multiple or involving general anaesthetic (unilateral)		55.60	6
	Choanal polypectomy			
# Z308	- unilateral		55.60	6
	Biopsy			
# Z309	- single		18.30	
# Z310	- multiple or involving general anaesthetic		50.90	6
	Removal of foreign body			
# Z311	- simple		10.55	
# Z312	- complicated, or involving general anaesthetic		50.90	6
# M010	Excision of intranasal lesions by lateral rhinotomy approach	5	493.90	7
# M011	Excision of other intranasal lesions (see General Preamble GP12)	I.C	I.C	I.C

RESPIRATORY SURGICAL PROCEDURES

NOSE

RECONSTRUCTION

		Asst	Surg	Anae
# M012	Septoplasty (when intranasal ethmoidectomies or antrostomies are done in addition, add 50% of the appropriate fees to M012, M013, M014, M015, M016, M019, M024)		252.15	6
# E840	- with repair of septal perforation add		119.20	
# M013	Partial septorhinoplasty (excluding osteotomies)		360.45	7
# E840	- with repair of septal perforation add		119.20	
# M014	Septorhinoplasty		484.15	7
# M019	- with autologous bone or cartilage graft - from site other than nose	5	690.35	7
# M024	- with non-autologous graft or implant	5	542.75	7
# E840	- with repair of septal perforation add		119.20	
# E642	- if performed by external approach using transverse columellar and rim incisions with elevation of nasal tip skin flap, to M012, M013, M014, M019, M024 add		119.20	
# R319	Graft to nose - autologous, bone or cartilage (without septorhinoplasty)	5	360.45	6
# R320	- non-autologous or prosthetic implant (without septorhinoplasty)	5	232.00	6

Note:
M013, M014, M019, M024, R319, R320 - claims for these procedures require Ministry of Health and Long-Term Care authorization. (see Surgical Preamble, paragraph 16).

		Asst	Surg	Anae
# M015	Septodermoplasty (to include fascial and other grafts)		306.85	6
# M016	Repair of septal perforation		358.70	6
# M017	Packing for localization of cerebrospinal rhinorrhea		39.60	6
# E603	- with fluorescein injection add		50.90	
# M033	Closure or opening of nostril for atrophic rhinitis		254.15	6
# M018	Endonasal augmentation for atrophic rhinitis - unilateral (including obtaining graft or preparing implant)		306.85	6
# M020	Repair of choanal atresia - uni- or bilateral	5	360.45	6
# M021	Puncture and insertion of tube for choanal atresia - uni or bilateral		123.70	6
# M028	Dilation of choanal atresia - uni- or bilateral		73.80	6

RESPIRATORY SURGICAL PROCEDURES

NOSE

RECONSTRUCTION

Rhinoplasty for reconstruction of cleft lip - nasal deformity

		Asst	Surg	Anae
# M030	- complex, to include necessary grafts and septoplasty	5	618.45	7
# M032	- tip and septum to include total take down of cleft lip		432.45	6
# M031	- tip and septum reconstruction to include minor lip repair (Minor revision, Z-plasty)		254.15	6

Note:
M030, M031, and M032 are not to be billed with repair of cleft lip.

TREATMENT OF EPISTAXIS (NASAL HAEMORRHAGE)

		Asst	Surg	Anae
Z314	Cauterization - unilateral		11.50	6
Z315	Anterior packing - unilateral		15.35	6
Z316	Posterior packing - uni - or bilateral		35.50	6
# M027	Ligation of external carotid artery - unilateral	6	297.25	6
# R788	Ligation of internal maxillary artery - unilateral	7	408.10	10
# R789	Ligation of anterior ethmoidal artery - unilateral	6	299.85	6
# Z313	Endoscopic transnasal ligation of the sphenopalatine artery for posterior epistaxis - unilateral		123.70	

RESPIRATORY SURGICAL PROCEDURES

ACCESSORY NASAL SINUSES

Code	Procedure	Asst	Surg	Anae
	Antrum or sinus lavage			
# Z319	Antral puncture and/or lavage - unilateral or bilateral		43.15	6

Note:
When a physician submits a claim for performing any insured surgical procedure on the same patient on the same day as the physician submits a claim for rendering Z319, the Z319 service is included (in addition to the common elements) as a specific element of that other insured service.

Code	Procedure	Asst	Surg	Anae
	Maxillary			
# M054	- intranasal antrostomy - unilateral	5	123.70	6
# M055	- Caldwell-Luc (intranasal antrostomy included) - unilateral	5	247.35	6
	Maxillectomy			
# M056	- partial or complete	7	776.70	10
# E947	- with orbital exenteration add		306.85	
# Z318	Frontal trephine or sinusotomy		133.30	6
# M058	Radical frontal sinusectomy		460.20	6
# M063	Coronal and/or osteoplastic procedure for frontal sinusectomy, reconstruction or obliteration - unilateral or bilateral	7	716.25	10
	External frontal-ethmoidal sinusectomy and/or reconstruction			
# M059	- unilateral	5	460.20	6
	Intranasal ethmoidectomy			
# M060	- unilateral		158.25	6
# E980	- when performed endoscopically add		41.25	
	External or transantral ethmoidectomy			
# M023	- unilateral (to include Caldwell-Luc with transantral approach)	5	360.45	6
# M061	Trans-septal sphenoidotomy or sphenoid sinusectomy		355.65	6
# M064	External transethmoidal sphenoidotomy or sphenoid sinusectomy	7	612.65	10
	Closure of antral fistula			
# M066	- minor		98.80	6
# M067	- complex or involving general anaesthetic (to include Caldwell-Luc if necessary)		345.15	6

RESPIRATORY SURGICAL PROCEDURES

LARYNX

		Asst	Surg	Anae
	ENDOSCOPY			
	Laryngoscopy			
# E600	- using operating microscope - to charges for laryngoscopy add		33.60	
	Direct			
# Z321	- with or without biopsy		61.30	6
# Z322	- with removal of foreign body		106.45	6
# Z323	- with removal of lesion(s)		148.60	6
# Z343	- with dilatation of larynx, to include bronchoscopy if necessary		202.35	6
	Indirect			
# Z324	- with biopsy or removal of foreign body		35.50	6
	INTRODUCTION			
# M080	Teflon augmentation larynx		182.10	6
	EXCISION			
	Laryngectomy			
# M081	- total	6	838.90	13
# E882	- with hemi thyroidectomy add		177.40	
# E883	- with subtotal thyroidectomy add		266.60	
# E884	- with total thyroidectomy add		374.00	
# M082	Laryngofissure	6	444.80	8
	Note: Excision to include laryngoscopy.			
	Laryngectomy			
# M084	- segmental, including reconstruction	6	888.85	9
# M085	Arytenoidectomy or arytenoidopexy or lateralization procedure.	6	395.05	8
	REPAIR (TO INCLUDE LARYNGOSCOPY)			
# M090	Laryngoplasty - e.g. repair of stenosis and fractures, transections - not to be billed with M084		642.45	6
# M089	Creation of tracheo-oesophageal fistula	5	197.45	6
# Z320	Insertion of voice prosthesis		25.85	
# Z303	Removal of laryngeal stent or keel.		103.60	6

RESPIRATORY SURGICAL PROCEDURES

TRACHEA AND BRONCHI

PREAMBLE

1. When laryngoscopy and bronchoscopy or oesophago-bronchoscopy are carried out as combined procedures, the physician should claim for one or the other but not both.
2. No claim should be made for bronchoscopy carried out immediately following thoracic surgery under the same anaesthetic by the same surgeon.
3. If bronchoscopy has been performed by the same physician on a patient in the 3-week period preceding a major lung resection, the amount payable for bronchoscopy performed the same day as the major lung resection (including intraoperatively) is reduced to nil.

ENDOSCOPY

Bronchoscopy

			Asst	Surg	Anae
# Z327	- with or without bronchial biopsy, suction or injection of contrast material		nil	112.55	6
# E632	- with removal of foreign body	add		64.55	2
# E633	- with dilatation of stricture	add		44.55	
# E634	- with selective endobronchial blocker or catheter insertion	add		44.55	
# E635	- with palliative endobronchial tumour resection including laser or cryotherapy	add		64.55	
# E636	- with broncho-alveolar lavage for obtaining specimens suitable for differential cellular analysis (for assessment of interstitial lung disease)	add		24.80	
# E637	- with selective brushings of all 18 segmental bronchi for occult carcinoma in situ; specimens labeled as to site	add		69.30	
# E638	- with transbronchial lung biopsy under image intensification only	add		74.30	
# E622	- any bronchoscopic procedure for patients under 3 years of age	add		79.40	2
# E677	- transbronchial needle aspiration (TBNA) of mediastinal and/or hilar lymph nodes	add		94.30	
# E678	- TBNA of lung mass	add		94.30	
# Z342	Limited bronchoscopy with placement of endobronchial blocker and/or double lumen tube			112.55	
# Z359	Repeat bronchoscopy for tracheobronchial toilet when performed within one week of another bronchoscopic procedure			51.00	6

Quadroscopy or panendoscopy

			Asst	Surg	Anae
# Z355	- with or without biopsy (nasopharyngoscopy, laryngoscopy, bronchoscopy, oesophagoscopy with or without gastro-duodenoscopy) using separate instruments in search of malignant disease			182.00	6

RESPIRATORY SURGICAL PROCEDURES

TRACHEA AND BRONCHI

TRACHEO-BRONCHIAL ASPIRATION

		Asst	Surg	Anae
# Z344	First procedure		37.05	
# Z345	Subsequent procedures performed by same physician		18.60	

Note:
Not to apply to:

1. operating surgeons,
2. when respiratory unit fees apply, or
3. within the first two hours post-operatively.

		Asst	Surg	Anae
# Z326	Change of tracheostomy tube		11.25	
# Z346	Transtracheal aspiration		22.35	
# Z356	Closure of persistent tracheostoma		133.95	6

INCISION

		Asst	Surg	Anae
# Z741	Tracheotomy	5	156.90	6
# E639	- with anterior cricoid split add		78.50	
# Z738	Insertion of Montgomery "T" Tube or similar laryngeal or tracheal stent	5	216.10	8

EXCISION

		Asst	Surg	Anae
E623	- repeat operation after 30 days add		415.15	
# M099	Segmental resection of cervical trachea	9	812.25	10
# E631	- with resection of cricoid add		314.20	
# M103	Segmental resection of trachea with either sternotomy or thoracotomy	9	1294.20	13
# M104	Carinal resection (without pulmonary resection)	11	825.40	15

REPAIR

		Asst	Surg	Anae
# M100	Tracheal rupture, transcervical	9	654.30	10
# M101	Tracheal-bronchial rupture, transthoracic	9	868.15	13

RESPIRATORY SURGICAL PROCEDURES

CHEST WALL AND MEDIASTINUM

		Asst	Surg	Anae
	EXCISION			
# M105	Chest wall tumour, resection of 2 or 3 ribs or cartilages	9	517.40	13
	Chest wall reconstruction			
# E640	- after chest wall resection where a significant defect (minimum 5 cm in diameter) remains requiring repair with synthetic material add		179.55	
# E601	- for each additional rib (more than 3) to a maximum of 3 additional add		57.50	
# E602	- with sternal resection add		177.95	
# M107	Total sternectomy	9	812.25	13
# N284	Excision of first rib and/or cervical rib to include scalenotomy when required	6	408.00	6
# M106	Mediastinal tumour	9	649.90	13
# M108	Ligation of thoracic duct - as sole procedure	6	410.45	6
	REPAIR			
	Chest wall - pleura			
# M109	- closed (see General Preamble GP12)		IC	6
# M110	- open (see General Preamble GP12)		IC	13
# M116	- fixation for trauma	5	350.00	6
# E604	- for fixation of each additional rib exceeding four ribs. add		55.60	2
# M117	Sternal fixation for trauma	5	251.45	6
# R352	Pectus excavatum or carinatum repair (by reconstruction, not implant)	6	690.45	11
	SURGICAL COLLAPSE			
	Thoracoplasty			
# M111	- one stage	9	304.20	10
# E605	- for each additional rib (more than 3) to a maximum of 3 additional add		55.60	
# Z742	Phrenicotomy	5	106.45	6

RESPIRATORY SURGICAL PROCEDURES

CHEST WALL AND MEDIASTINUM

		Asst	Surg	Anae
	INCISION			
# Z353	Incisional biopsy of chest wall tumour	5	89.45	6
# Z354	Excisional biopsy of rib for tumour	5	142.20	6
# Z357	Thoracic window creation	5	228.25	7
# Z358	Thoracic window closure	5	111.20	6
	ENDOSCOPY			
# Z329	Mediastinoscopy	5	187.30	6
# Z330	- with bronchoscopy	5	248.15	6
# Z333	- with transbronchial biopsy under image intensification (including bronchoscopy)	5	275.25	6
# Z328	- with mediastinotomy	5	274.65	6
# Z348	- with bronchoscopy and mediastinotomy	5	349.70	6
	Anterior mediastinotomy			
# Z347	- when sole procedure performed	5	198.10	6

RESPIRATORY SURGICAL PROCEDURES

LUNGS AND PLEURA

		Asst	Surg	Anae
	INTRODUCTION - THORACENTESIS			
Z331	Aspiration for diagnostic sample		25.15	
Z332	Aspiration with therapeutic drainage with or without diagnostic sample		45.85	6
E606	- administration of chemotherapy or sclerosing agent add		23.25	
E542	- when performed outside hospital add		11.15	
# Z334	Total unilateral lung lavage with or without bronchoscopy using Double Lumen Tube and single lung anaesthesia		304.60	13
	ENDOSCOPY			
# Z335	Thoracoscopy (pleuroscopy) with or without pleural biopsy, suction, etc.		111.20	6
	INCISION			
# Z340	Biopsy of lung, needle		91.90	6
# Z336	Biopsy of pleura, needle - including diagnostic aspiration		45.85	6
# Z341	Closed drainage effusion or pneumothorax		62.85	6
# E606	- with administration of chemotherapy or sclerosing agent add		23.25	
# Z337	Rib resection for drainage	6	126.75	6
# M133	Thoracotomy for removal of foreign body	9	390.65	13
# M137	Thoracotomy with or without biopsy	9	390.65	13
# M134	Thoracotomy for post-operative haemorrhage or empyema	9	390.65	13
# M132	Thoracotomy with repair of ruptured diaphragm	9	507.45	13
# M130	Closure of broncho-pleural fistula (transthoracic or trans-sternal)	9	584.75	13
# E609	- with intercostal muscle bundle add		121.70	
# E610	- with myovascular flap (pectoralis major, latissimus dorsi, rectus abdominus) add		263.80	
# M135	Major decortication of lung for empyema or tumour	11	593.60	15
# Z339	Intercostal drainage with insufflation of sclerosing agent under general anaesthesia	5	182.90	6

CARDIOVASCULAR SURGICAL PROCEDURES

PREAMBLE

1. Excision or repair procedures for arteries and veins include endartectomy, thrombectomy and/or bypass graft.

2. Excision or repair procedures for arteries and veins include harvest of graft tissue, except where harvest of graft tissue is explicitly excluded from the procedure. Where harvest of graft tissue is included as a specific element of the procedure, the harvest is an insured service payable at nil.

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

Note:
Preliminary diagnostic catheterization - extra to operative fees (see Diagnostic and Therapeutic Procedures). The basic anaesthetic fee of 28 units for major cardiovascular surgery includes such procedures as insertion of C.V.P. line (G268), arterial line, blood sampling, blood analysis and interpretations.

Code	Description		Asst	Surg	Anae
# R700	With hypothermia and without bypass - basic fee for cardiovascular procedures			-	25

Note:
R700 replaces procedural basic code when hypothermia is used where basic is less than 25 units.

Code	Description		Asst	Surg	Anae
# Z759	Removal of failed vascular graft without arterial reconstruction - when sole procedure			189.55	6
# E655	- re-operation for failed vascular grafts - for repair or replacement of existing prosthesis (more than one month after original operation)	add		174.35	

Pump bypass

Code	Description		Asst	Surg	Anae
# E650	- includes cannulating and decannulating heart or major vein, major artery, supervision of pump and pump run	add		366.50	28
# E682	- axillary artery graft for cardiopulmonary bypass, to E650	add		423.85	

Note:
Anaesthesiologist - see General Preamble GP54 to GP58.

Circulatory assist device e.g. intra-aortic balloon

Code	Description	Asst	Surg	Anae
# Z743	- open		307.80	6
# Z780	- percutaneous		219.80	6

Note:
Includes cannulation, repair of artery, daily care and supervision.

Decannulation of circulatory assist device

Code	Description	Asst	Surg	Anae
# Z744	- open		123.05	6
# Z781	- percutaneous		39.00	

Note:

1. Includes repair of artery.
2. R815 not to be claimed in addition to Z744.

Repositioning of intra-aortic balloon pump

Code	Description	Asst	Surg	Anae
# Z751	- open		127.95	6
# Z782	- percutaneous		82.55	

Note:
No claim to be made for repositioning within 24 hrs of original insertion.

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae
	Re-operation involving open heart procedures with pump			
# E670	- following previous thoracotomy ... add		224.70	
# E671	- following previous sternotomy ... add		337.00	
	Note: More than one month after original operation.			
	Cardiac massage			
# R765	- open	13	231.30	13
	Note: For closed massage - see Critical Care - Diagnostic and Therapeutic Procedures.			
# Z433	Replacement of pacemaker pack (single or multiple leads)		146.45	6
# Z444	Insertion of permanent endocardial electrode and implantation of pack, includes insertion of temporary transvenous lead at same surgical procedure by same surgeon	5	323.75	6
# Z445	Repositioning of permanent endocardial electrode (as separate procedure)		323.75	6
# Z435	Insertion of permanent endocardial electrode(s)		154.10	
# Z436	Exposure of vein and implantation of pack		166.55	6
# R752	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes	5	454.55	6
# R751	Implantation of epicardial electrode(s) plus implantation of pack	6	465.00	20
# Z429	Implantation of coronary sinus lead for biventricular pacing	5	299.25	8
	Implantation of ventricular assist device			
# R701	- uni-ventricular	18	721.60	28
# R702	- bi-ventricular	18	1334.80	28
# Z412	Replacement or repair of pacemaker lead	5	110.75	6
# Z428	Pacemaker lead extraction, including the use of extraction sheathes, with or without laser or similar technology	10	598.50	7
# E628	- each additional lead extraction ... add		194.50	
	Implantation of cardioverter (CD) defibrillator			
# R753	- by thoracotomy	6	720.30	20
# R761	- by transvenous approach	5	587.35	8
	Note: Induction of ventricular arrhythmia at time of CD implant payable at 85%. See note re: G259 in Diagnostic and Therapeutic Procedures.			
# Z415	Removal and/or replacement of implantable cardioverter defibrillator	5	339.45	6

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

			Asst	Surg	Anae
	Thoracotomy				
# M137	- with or without biopsy		9	390.65	13
# M134	- for post-operative haemorrhage		9	390.65	13
# Z401	Aspiration of pericardium			131.70	
# Z414	Injection of pericardial sclerosing agents			23.10	
# R750	Open biopsy of pericardium and drainage (transthoracic or epigastric)		13	317.85	13
	Pericardiectomy				
# R748	- one side open		13	635.45	20
# R749	- both sides open or sternal split		13	1001.40	20
	Cardiotomy				
# R712	- with exploration		18	525.75	20
# R713	- with removal of foreign body		18	635.45	20
# R714	- with removal of tumour		18	525.75	20
# E660	- epicardial E.P.S. mapping	add		185.15	
# E661	- endocardial E.P.S. mapping	add		185.15	
# E658	- HIS Bundle ablation	add		278.10	
# R711	Division of accessory conduction pathway (to include cardiotomy, mapping with or without HIS bundle)			741.55	20
# R709	Atrial ablative procedure for surgical treatment of atrial arrhythmia (either Cox-Maze procedure or performed using an energy source)		18	741.55	20
# R710	Resection/ablation for ventricular tachycardia (to include cardiotomy, mapping with or without HIS bundle)			1112.15	20
	EXCISION				
# R920	Ventricular tumour		18	712.15	28
# R746	Ventricular aneurysm		18	864.50	28
# R747	Aneurysm of sinus of Valsalva		18	783.55	28
# R741	Coronary artery endarterectomy and/or gas endarterectomy		18	730.70	20
# E651	- when done in conjunction with coronary artery repair	add		202.05	

Note:
R741, E651 - for multiple or complex procedures, assessment by the Medical Consultant is available and may be requested.

			Asst	Surg	Anae
# E648	- excision of extensive endocardial scar, to ventriculotomy or aneurysm repair	add		135.80	
	Coronary artery repair				
# R742	- one		18	895.55	20
# R743	- two		18	1202.45	20
# E654	- each additional	add		187.70	

Note:
Where a single segment of vein is used for more than 2 anastomoses, the second and subsequent anastomoses are to be claimed at 50% of the E654 fee.

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

			Asst	Surg	Anae
# E652	- use of internal mammary or epigastric or radial artery for construction of bypass graft	add		183.00	
# E646	- vein patch angioplasty of coronary artery	add		187.80	
	Interruption of bronchial collateral arteries (one or more arteries)				
# R857	- as sole procedure		13	730.70	20
# E663	- when done in conjunction with other cardiac surgery	add		183.00	
	Ligation or division patent ductus				
# R754	- infant or child		13	525.75	20
# R755	- adolescent or adult		13	730.70	20
	Resection coarctation				
# R757	- infant		13	785.90	20
# R756	- child		13	755.80	20
# R758	- adolescent or adult		13	967.10	20
# R759	Congenital heart procedures - e.g. Blalock, Glenn, Potts, Waterston or Central		13	755.80	20
	Creation of ASD				
# R763	- by balloon septostomy		9	317.85	9
# R762	- by thoracotomy or Sterling Edwards		18	755.80	20
	Closure of atrial septal defect				
# R715	- secundum		18	755.80	20
# R716	- endocardial cushion and valve defect		18	1124.70	20
# R717	- with anamalous pulmonary venous drainage		18	948.75	28
# R718	Closure of ventricular septal defect		18	948.75	28

Note:
R718 should be claimed only once regardless of the number of defects repaired by one patch.

Percutaneous transluminal catheter assisted closure for Secundum arterial septal defect

		Asst	Surg	Anae
Z465	- device closure of a single defect		198.55	
Z466	- device closure of two or more defects		347.45	

Note:
A maximum of 2 services of either Z465 or Z467 are eligible for payment if the services are rendered by 2 different physicians, same patient same day.

		Asst	Surg	Anae
# R870	Orthotopic cardiac transplantation	18	1443.05	28
# R872	Donor cardiectomy	7	481.40	8
# R874	Cardiopulmonary transplantation	18	2534.25	28
# M157	Donor Heart - Lung removal	8	906.45	8

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

REPAIR

		Asst	Surg	Anae
# R720	Total repair Tetralogy of Fallot - with or without previous arterial shunt	18	1261.80	28
# R722	Total anomalous pulmonary venous drainage	18	1124.70	28
# R723	Total correction transposition of great vessels	18	1124.70	28
# R721	Arterial repair of transposition	18	1687.50	28
# R921	Complete A-V canal	18	1480.40	28
# R922	Single ventricle	18	1687.50	28
# R923	Double outlet - right/left ventricle	18	1480.40	28
# R924	Double outlet ventricle with transposition	18	1687.50	28
# R925	Truncus arteriosus	18	1687.50	28
# R926	Interrupted aortic arch	18	1480.40	28
# R927	Aorto-pulmonary window	18	948.75	28
# R928	R-V outflow tract with valve and tubular graft	18	1064.55	28
# R929	Debanding arterioplasty of pulmonary artery	18	943.45	28
# R768	Pulmonary artery banding	13	628.95	20
# R769	- with pressure studies by anaesthetist, extra/hour		-	6
# R770	Correction of cor triatriatum	18	864.40	20
# R771	Vascular ring	18	755.80	20

CARDIOVASCULAR SURGICAL PROCEDURES

VALVES

		Asst	Surg	Anae
# R724	Pulmonary valvotomy	18	663.10	28
# R725	Pulmonary valvotomy and infundibular resection	18	758.80	28
# R772	Pulmonary valve replacement	18	758.80	28
# R726	Tricuspid valvotomy	18	778.25	20
# R727	Tricuspid annuloplasty	18	662.55	20
# R728	Tricuspid valve replacement	18	758.80	28
# R729	Mitral valvotomy	18	717.25	20
# R730	Mitral valvotomy - restenosis	18	798.80	20
# R734	Mitral annuloplasty	18	770.70	20
# R735	Mitral replacement	18	933.55	28
# R733	Mitral valvoplasty	18	963.40	28
	Mitral valve reconstruction			
# R773	- simple (includes annuloplasty)	18	1618.50	28
# R774	- complex (includes annuloplasty and repair of both the anterior and posterior leaflets)	18	2021.05	28
# R930	Aortic valvoloplasty	18	837.70	28
# R736	Aortic valvotomy	18	707.85	20
# R737	Aortic infundibular resection (ventriculomyotomy)	18	869.70	28
# R738	Aortic valve replacement	18	1010.55	28
# E647	- patch aortoplasty with pericardium or graft, to R738 and/or aortic annuloplasty . . . add		264.70	
# E656	- aortic annuloplasty (reconstruction and enlargement of aorticannulus), to R738 and/or patch aortoplasty . . . add		288.85	
# R863	Replacement of aortic valve, replacement of ascending aorta, and reimplantation of coronary arteries (Modified Bentall)	18	2021.05	28
# R876	Valve sparing aortic root replacement or remodelling	18	2021.05	28

Note:
Multivalvular replacement - the fee will be that for the major valve replaced plus 85% of the fee for the additional valve or valves.

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
	Cannulation for infusion chemotherapy			
# R775	- superficial temporal artery	5	95.80	6
# R776	- hepatic artery	6	212.15	6
# R778	- carotid artery	5	148.50	6
# R760	Regional isolation perfusion e.g. iliac	10	410.45	10
# R764	Exploration of major artery	6	271.60	10

INCISION

		Asst	Surg	Anae
# Z402	Arteriotomy		117.30	6

Note:
Z402 not allowed in addition to other major cardiovascular surgery.

REPAIR

Traumatic

		Asst	Surg	Anae
# R790	Suture of lacerated major artery	5	316.85	10
# R795	Repair of lacerated major artery or microscopic repair of digital artery (including patch angioplasty)	10	498.65	10
# R862	- by bypass or interposition graft	10	662.15	10

LIGATION

		Asst	Surg	Anae
# R781	Ligation of artery - as sole procedure	5	170.10	8
# R788	Internal maxillary artery - Caldwell Luc approach	7	408.10	10
# R789	Anterior ethmoid artery	6	299.85	6
# R708	Internal iliac artery (unilateral or bilateral)	7	409.55	10

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

Code	Procedure	Asst	Surg	Anae
	Mesenteric or celiac artery repair			
# R811	- aneurysm	10	410.85	10
# R935	- removal of band only	10	410.85	10
# R936	- endarterectomy or graft	10	867.35	10

Note:
Use R935 for excision of celiac ganglion.

Code	Procedure	Asst	Surg	Anae
# R940	Pulmonary thromboendarterectomy (PTE) - includes circulatory arrest with hypothermia	18	2021.05	28
	Aorto-Iliac repair			
# R783	- including common iliac repair (uni- or bilateral)	10	1012.00	17
# R784	- plus unilateral common femoral repair	10	1187.15	17
# R785	- plus bilateral common femoral repair	10	1314.25	17
# E626	- plus implantation of inferior mesenteric artery add		174.35	
# R814	- embolectomy or thrombectomy of bifurcation (aorta or graft)	10	461.50	10
# R858	Total removal of infected aortic graft (stem and limbs)*	10	918.35	17
# E664	- closure of duodenum add		127.05	
# R859	Partial removal of infected aortic graft (one limb only)*	10	344.00	10

Note:
* Arterial reconstruction extra.

Code	Procedure	Asst	Surg	Anae
# R805	Renal artery - aneurysm - reconstruction or excision with graft	10	867.35	10
# R806	Renal artery repair	10	867.35	10
# R807	Splenic artery aneurysm - reconstruction or excision with graft	10	411.05	10
# R786	Iliac repair to include internal iliac aneurysm	10	805.65	10
# R937	Ilio-femoral bypass graft	10	805.65	10
	Per-obturator ilio-femoral graft			
# R860	- with saphenous vein	10	898.55	10
# R861	- with prosthetic graft	10	876.85	10
	Profundoplasty			
# R855	Common femoral/profunda femoris repair - as sole procedure	10	559.20	10
# R856	Extended profundoplasty	10	779.80	10
# R933	Axillo-femoral, femoro-femoral or axillo-axillary graft	10	656.55	10
# R934	Aorto-femoral unilateral graft (for bilateral see R785)	10	867.35	17
# R808	Femoral aneurysm - reconstruction or excision with graft	10	600.30	10
# R873	Thrombin injection of femoral artery pseudoaneurysm		55.00	6

Note:
J202/J502 is payable when rendered in conjunction with R873.

Code	Procedure	Asst	Surg	Anae
# R864	Repair of false aneurysm at groin anastomosis	10	893.20	10

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
# R809	Femoral-popliteal endarterectomy	10	759.60	10
	Femoro-popliteal			
# R791	- with saphenous vein	10	857.35	10
# E672	- composite femoral popliteal/tibial bypass (vein PFPE, dacron) add		133.40	
# R794	- with prosthetic graft	10	733.15	10
	Femoro-anterior/posterial tibial/peroneal bypass graft			
# R787	- with saphenous vein	10	1006.75	10
# E672	- composite femoral popliteal/tibial bypass (vein PFPE, dacron) add		133.40	
# R780	- with prosthetic graft	10	878.00	10

Note:
R791, E672, R794, R787, E672, R780 with or without endarterectomy.

		Asst	Surg	Anae
# R810	Popliteal aneurysm	7	805.65	10
# R812	Peripheral arteries other than listed - aneurysm	7	410.45	10
# R813	Embolectomy - artery or graft - as sole procedure	7	322.45	10
# R867	Thrombectomy - artery or graft - as sole procedure	7	303.10	10
# E649	- embolectomy and/or thrombectomy when done in conjunction with other vascular procedures add		112.45	
# R866	Gastric devascularization - as sole procedure	10	549.65	10
	In-situ saphenous vein arterial bypass			
# R797	- popliteal	10	1285.40	17
# R804	- tibial	10	1490.25	17

CARDIOVASCULAR SURGICAL PROCEDURES

VEINS

		Asst	Surg	Anae
	EXCISION			
	Resection of AV aneurysm or fistula with or without major graft			
# R825	- major aneurysm	10	975.50	17
# R826	- minor aneurysm	10	497.25	10
	LIGATION			
# Z745	Saphenous		53.20	6
# Z746	Femoral	5	74.25	6
# Z747	Popliteal	5	74.25	6
# Z748	Internal jugular	5	148.60	6
# R839	Internal iliac	6	394.85	10
# R834	I.V.C. - transabdominal	6	446.50	10
# R838	I.V.C. - transvenous (umbrella)	6	303.00	10
# R868	High ligation and stripping of long saphenous vein with groin dissection	5	148.60	6
# R869	Stripping of short saphenous vein with popliteal dissection	5	107.50	6
# R837	Multiple ligation and avulsion	5	148.60	6
# R844	Recurrent varicose veins - multiple ligation and/or stripping	5	353.80	6
# R842	Extra fascial and sub-fascial incompetent perforators by full fascial technique	5	384.75	6
# E653	- plus stripping add		127.15	

CARDIOVASCULAR SURGICAL PROCEDURES

VEINS

		Asst	Surg	Anae
	REPAIR			
# R820	Lacerated major vein e.g. femoral, popliteal, vena cava, axillary, sub-clavian, brachial or microscopic repair of digital vein	5	317.55	6
# R818	- including patch	10	497.25	10
# R819	- by vein graft	10	661.30	10
# R835	S.V.C. bypass graft	7	758.40	17
# R836	Pulmonary embolectomy	18	866.55	20
# R828	Ilio-femoral thrombectomy with or without femoral vein ligation	10	446.50	10
# E657	- plus I.V.C. ligation add		446.50	
# R829	Thrombectomy, other than above	7	302.80	10
# R865	Distal spleno-renal shunt	10	1259.55	10
	ANASTOMOSIS			
# R822	Porto-caval	10	919.10	10
	Spleno-renal			
# R823	- abdominal approach	10	1117.90	10
# R821	- transthoracic approach	10	1117.90	13
# R824	Meso-caval	10	866.55	10
# R827	Creation of A.V. fistula	5	360.25	6
# R841	Obliteration of A.V. fistula		82.55	6
# R833	Ligation or removal of by-pass graft		82.55	6

HAEMATIC AND LYMPHATIC SURGICAL PROCEDURES

SPLEEN AND MARROW

INCISION

		Asst	Surg	Anae
# Z404	Splenic puncture and aspiration		81.00	6
# Z403	Bone marrow aspiration		33.90	
# Z408	Bone marrow core biopsy (with biopsy needle)		63.35	6

Note:

1. If Z403 and Z408 are both performed through the same site or with the same biopsy needle, only Z408 is eligible for payment. Maximum of 1 Z408 per patient, per day.
2. If the aspiration does not result in any material for examination, the service is not eligible for payment.

[Commentary:
If Z408 and Z403 are performed through different sites, both services are payable.]

Bone marrow transplantation - team fee

# Z425	- aspiration from donor		506.75	8
# Z426	- infusion into recipient		62.55	6

[Commentary
Bone marrow transplantation is not an insured benefit for treatment of some conditions. Please refer to ministry of Health and Long-Term Care Medical Consultant for qualifying diagnoses.]

Note:
Bone marrow interpretation: see Diagnostic and Therapeutic Procedures - Laboratory Medicine.

EXCISION

# R905	Splenectomy - partial or complete	7	493.90	7
# E793	- laparoscopic or laparoscopic assisted, to R905 add 25%			

HAEMATIC AND LYMPHATIC SURGICAL PROCEDURES

LYMPH CHANNELS

		Asst	Surg	Anae
	ANASTOMOSIS			
# R846	Micro lympho - lympho or lymphovenous	7	691.40	7
	INCISION			
# Z410	Drainage of sub-fascial abscess		74.50	6
# Z413	Scalene node fine needle aspiration		28.40	
	EXCISION			
	Cystic hygroma			
# R907	- unilateral	5	408.65	6
	Neck			
# R910	- limited, e.g. sub mandibular supra omohyoid	6	271.05	6
# R911	- radical	6	843.35	8
# R915	- modified radical including functional with preservation of spinal accessory nerve	6	906.45	8
# R912	Ileoinguinal, radical resection	6	489.30	8
	Axillary or inguinal node			
# R913	- radical resection - unilateral	5	367.95	6
# R914	- limited resection	5	207.30	6
	BIOPSY			
# Z405	Anterior cervical, axillary, inguinal	5	62.95	6
# Z406	Scalene, posterior cervical	5	125.85	6
# Z578	Multiple para-aortic lymph nodes	6	75.00	6
	Percutaneous retro peritonea			
# Z407	- one group	5	87.15	6
# Z409	- two or more groups	5	130.80	6
# R916	Re-exploration of vascular graft and closure of lymph fistula in groin	5	207.30	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ORAL CAVITY AND PHARYNX

Note:
To include nasopharynx, oropharynx, hypopharynx except where otherwise specified.

		Asst	Surg	Anae
	INCISION			
# Z506	Drainage of oral abscess or haematoma		50.90	6
# Z510	Drainage of pharyngeal abscess or haematoma		91.10	6
# Z524	Drainage of haematoma or deep neck abscess (external approach)	5	153.35	6
Z501	Biopsy		35.50	
E542	- when performed outside of hospital add		11.15	
# Z537	- requiring general anaesthetic		76.70	6
	Tongue tie, release of			
Z111	- simple		15.35	
# Z112	- complex or requiring general anaesthetic		50.90	6
# S031	Palatal fenestration		197.55	6
	EXCISION			
	Lesion			
Z502	- less than 2 cms	5	71.00	6
S003	- 2 to 4 cms, inclusive	5	212.80	6
S006	- over 4 cms	5	342.30	6
E542	- when performed outside of hospital add		11.15	
S004	Ranula	5	165.80	6
S005	Composite resection of lesion of oral cavity and/or oropharynx with partial resection of mandible	10	897.45	12
S007	Extended composite resection of lesion of oral cavity and oropharynx with partial resection of mandible and resection of maxilla	10	1059.45	12
# S050	Cryotherapy for treatment of pre-malignant or malignant lesions of oral cavity or sinuses		148.60	6
	Glossectomy			
# S018	- partial	6	197.45	8
# S019	- complete	6	281.95	8
# Z109	Wedge excision of lesion		61.30	6
# S020	Glossoplasty	5	197.45	6
	Extraction of tooth (complete care)			
S023	- single		24.90	6
E700	- each additional tooth add		13.40	
# S028	Dentigerous cyst	5	98.80	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ORAL CAVITY AND PHARYNX

		Asst	Surg	Anae
# S900	Basic units for anaesthesia with any unlisted dental surgical procedure performed by dental or oral surgeon (see General Preamble GP58, also Bulletin #4203)			8
# S021	Repair of extensive laceration (see General Preamble GP12)	5	I.C	I.C
	Note: For minor lacerations - see Skin.			
# S034	Cleft palate repair	6	369.25	8
# S035	Removal of sutures under general anaesthesia		41.25	6
# S032	Bone graft to palate	6	335.65	8
	Closure of fistula			
# S030	- anterior alveolar	5	197.45	6
# S033	- palate	6	281.95	8
# S036	Uvulopalatopharyngoplasty (includes tonsillectomy)		239.75	6
# S069	Pharyngoplasty	8	360.45	8
# S002	Excision of parapharyngeal space lesions (with mobilization of parotid gland)	5	612.65	8
# S067	Partial pharyngectomy - transthyroid or lateral	8	791.00	11
# S068	Pharyngo-laryngectomy	8	1155.45	14
# E882	- with hemithyroidectomy add		177.40	
# E883	- with subtotal thyroidectomy add		266.60	
# E884	- with total thyroidectomy add		374.00	
	Branchial			
# S058	- cleft lesion	5	306.85	6
# S059	- repeat procedure	5	435.30	6
# S061	Thyroglossal duct remnant	5	306.85	6
# S062	- repeat procedure	5	410.40	6
# S063	Tonsillectomy and may include adenoidectomy		178.35	6
# S065	Adenoidectomy		101.25	6
	Secondary suture or cauterization following tonsillectomy and/or adenoidectomy			
# S066	- when haemorrhage occurs after initial procedure		59.50	6
# S024	Excision of torus palatinus	5	197.45	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

SALIVARY GLANDS AND DUCTS

		Asst	Surg	Anae
	INCISION			
# Z500	Sialolithotomy		30.65	
# Z521	- requiring general anaesthesia	5	103.60	6
	EXCISION			
# S042	Submandibular gland or sublingual gland	5	287.75	6
	Parotid gland			
# S043	- total (with preservation of facial nerve)	6	690.90	8
# S044	- total (without preservation of facial nerve)	6	593.00	8
# S045	- subtotal (with preservation of facial nerve)	6	642.35	7
# S047	- repeat subtotal (with preservation of facial nerve)	6	690.90	7
# S046	- subtotal (without preservation of facial nerve)	6	395.45	6
# Z522	Excision small tumour	5	51.25	6
	RECONSTRUCTION			
# S049	Plastic repair of duct	5	202.25	6
Z511	Dilation and/or probing of duct		30.65	6
# S057	Submandibular duct relocation	6	360.75	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

LIPS

		Asst	Surg	Anae
	INCISION			
# Z503	Biopsy		35.40	6
E542	- when performed outside of hospital add		11.15	
	EXCISION			
	Wedge resection of lip			
# S011	- vermilion	5	98.45	6
# S010	- with plastic repair		239.00	6
Z504	Excision of lesion	5	61.15	6
E542	- when performed outside of hospital add		11.15	
# S012	Lip shave vermilionectomy	5	201.70	6
	RECONSTRUCTION			
	Cleft lip			
# S013	- unilateral	6	363.30	8
# E501	- with nasal cartilage realignment add		304.30	
# S014	Reconstruction with lip switch flap	6	444.40	8
# S015	Complex reconstruction or revision of previous repair and excision (see General Preamble GP12)		I.C	I.C

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ENDOSCOPIC ULTRASOUND

Radial or linear probe through endoscope

			Asst	Surg	Anae
# E800	- to endoscopy fee	add		101.50	
# E801	- including biliary and/or pancreatic examination, to endoscopy fee	add		152.30	

Note:

The amount payable for E800 when rendered in conjunction with E801 is zero.

Linear or radial echo-endoscope

			Asst	Surg	Anae
# S236	- excluding biliary or pancreatic examination (scope also used for therapeutic procedures)		nil	203.05	6
# S237	- including biliary and/or pancreatic examination (scope also used for therapeutic procedures)		nil	253.80	6
# E802	- biopsy or fine needle aspiration, to a maximum of 3, per lesion	add		50.75	
# E803	- dilation of stricture	add		30.65	
# E804	- injection of one or more of any of the following - metastases, nodes, masses, or celiac plexus	add		145.05	
# E805	- drainage of pseudocyst (including stent insertion if performed)	add		203.05	

Note:

1. The amount payable for S236 when rendered in conjunction with S237 is zero.
2. The amount payable for upper and/or lower GI endoscopy rendered in conjunction with S236 or S237 is zero unless the upper and/or lower GI endoscopy is required due to the limited visualization with the linear or radial echo-endoscope.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

OESOPHAGUS

For procedures on the oesophagus, the following basic units for assistants and anaesthesiologists will apply except if a basic fee is listed.

			Asst	Surg	Anae
# S073	Cervical approach		6	-	7
# S074	Thoracic approach		10	-	13
# S075	Abdominal approach		7	-	8

ENDOSCOPY

			Asst	Surg	Anae
# Z515	Oesophagoscopy, with or without biopsy(ies)			68.25	6
	Oesophagoscopy-gastroscopy, with or without duodenoscopy				
# Z399	- elective		nil	102.75	6
# Z400	- for active bleeding		nil	125.10	6
# E696	- with dilatation of oesophagus	add		30.65	
# E702	- with multiple (3 or more) biopsies of specific lesion	add		15.10	
# E690	- with removal of foreign body(ies)	add		43.85	
# E795	- with brushing of oesophagus, stomach, and/or duodenum	add		46.30	
# E770	- with duodenoscopy and drainage of bile after I.V. CCK stimulation	add		23.10	
# E692	- with laser debulking	add		69.70	
# E698	- with pneumatic or balloon dilation	add		69.70	
# E703	- with snare polypectomy first polyp (> 1 cm)	add		50.50	
# E799	- each additional polyp, by snare polypectomy (> 1 cm) (to a maximum of 2)	add		25.25	
# E695	- laser palliation of oesophageal tumour, extensive, complete obstruction (see General Preamble GP12)	add		I.C	
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.)	add		46.30	
# E798	- management of complicated upper gastrointestinal bleeding by any technique in haemodynamically unstable patients with active bleeding during endoscopy	add		69.70	
# E629	- endoscopic placement of stent in duodenum	add		137.05	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

OESOPHAGUS

		Asst	Surg	Anae
	INCISION			
	Oesophagostomy			
	Cervical			
# S084	- other than neonatal		212.35	
# S085	- neonatal		304.20	
	Intrathoracic oesophageal stent			
# S082	- via laparotomy		410.55	6
# S083	- via oesophagoscope (includes Z515)		304.20	6
# S081	Trans-oesophageal division of oesophageal varices		558.05	
# S080	Oesophageal-gastric devascularization (including splenectomy and oesophageal division/anastomosis)		898.15	
	EXCISION			
# S087	Intrathoracic diverticulum		507.00	
# S088	Cricopharyngeal diverticulum		390.05	
# E699	- with myotomy ... add		37.20	
# S089	Partial oesophageal resection and reconstruction (including intestinal transposition)		1081.55	17
# S090	Total thoracic oesophageal resection		1167.60	13
# E730	- with reconstruction ... add		540.90	6
# S093	Enucleation of benign oesophageal tumour		584.15	
	REPAIR			
# S161	Oesophageal myotomy, partial (below aortic arch)		584.15	
# E758	- with oesophageal hiatus hernia repair ... add		217.35	
# E699	- with diverticulum excision ... add		37.20	
# S100	Total thoracic oesophageal myotomy (as sole procedure)		738.90	
# E758	- with oesophageal hiatus hernia repair ... add		217.35	
	Oesophageal hiatus hernia			
# S091	- abdominal or transthoracic approach with fundal plication		550.60	
# S092	- recurrent		709.85	
# E793	- laparoscopic or laparoscopic assisted, to S091 or S092 ... add 25%			
# E744	- with gastroplasty, to either S091 or S092 ... add		115.80	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

OESOPHAGUS

		Asst	Surg	Anae
	REPAIR			
# E742	- when S091 or S092, with or without gastroplasty, is done in conjunction with cholecystectomy, and/or vagotomy with or without drainage procedures, add E742 to S091 or S092 (with or without E744) for each additional procedure performed. For any other combination of surgical procedures with oesophageal hiatus hernia repair (with the exception of S161 and S100), see Surgical Preamble SP3		217.35	
# S095	Oesophageal stricture (Thal) - may include oesophageal hiatus hernia repair with or without gastroplasty		676.05	
# S096	Ruptured oesophagus, suture and drainage		507.00	
# S097	Oesophago-gastrostomy for bypass (as sole procedure)		608.30	
	Oesophageal bypass, abdomen to neck			
# S098	- with stomach		912.60	
# S099	- with colon or jejunum		1264.05	
	SUTURE			
# S102	Closure of oesophago-tracheal fistula (includes oesophageal reconstruction and lengthening if necessary)		656.80	
	DILATION OF OESOPHAGUS			
	Passive (bougie)			
# Z529	- initial session		40.55	
# Z530	- repeat session (within three months following previous dilation)		27.35	
	Pneumatic			
# Z525	- as sole procedure		110.85	
# Z523	- with rigid dilators guided over a string or wire		52.90	
# Z531	Repeat dilations during the same admission		26.40	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

STOMACH

		Asst	Surg	Anae
	ENDOSCOPY			
	Gastroscopy			
# Z527	- may include biopsies, photography and removal of polyps less than or equal to 1 cm		92.10	6
# Z547	- with removal of foreign body		99.75	6
# Z528	- subsequent (within three months following previous gastroscopy)		67.85	6
# E674	- with snare polypectomy - 1st polyp > 1 cm (maximum 1) add		142.40	
# E675	- with snare polypectomy each - additional polyp > 1 cm (maximum 2) add		73.50	

Note:
E674, E675 are payable with Z527, Z547 or Z528.

		Asst	Surg	Anae
	INCISION			
	Gastrotomy			
# S116	- with removal of tumour or foreign body	6	406.85	7
# E731	- with suture of bleeding peptic ulcer add		82.35	2
# S117	Pyloromyotomy (Ramstedt's)	5	314.80	10
	Gastrostomy			
# S118	Gastrostomy	6	345.85	7
# E697	- with repair of Mallory-Weiss laceration add		142.40	
# E707	- when done with another intra-abdominal procedure		70.80	
# Z532	Percutaneous endoscopic gastrostomy	6	172.95	7
Z520	Change of gastrostomy tube		8.60	
	EXCISION			
	Biopsy - incisional			
# Z526	- by gastrostomy		73.60	
# Z533	- by intubation		36.80	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

STOMACH

			Asst	Surg	Anae
	GASTRECTOMY				
# S122	Wedge resection for ulcer		7	406.85	7
# E708	- with vagotomy	add		122.05	
# E713	- after previous partial gastrectomy	add		137.55	
	Partial or subtotal				
# S123	- distal		7	635.35	8
# S125	- proximal		7	691.55	8
# E731	- with suture of bleeding peptic ulcer	add		82.35	2
# E708	- with vagotomy	add		122.05	
# E709	- with cholecystectomy	add		122.05	
# E711	- after previous gastro-enterostomy	add		106.55	
# E706	- with choledochotomy	add		122.05	
# E712	- after previous vagotomy and pyloroplasty	add		111.10	
# E713	- after previous partial gastrectomy	add		137.55	
	Total gastrectomy				
# S128	- with or without splenectomy		7	951.20	9
# E709	- with cholecystectomy	add		122.05	
# E706	- with choledochotomy	add		122.05	
# E713	- after previous partial gastrectomy	add		137.55	
# S129	Conversion of previous gastrectomy to Roux-en-y		7	702.25	9
	Vagotomy				
# S131	- truncal or selective		7	375.80	7
# S124	- highly selective (as sole procedure without pyloroplasty or gastroenterostomy)		7	503.10	7
# S121	Transabdominal vagotomy after previous vagotomy		7	416.50	8
# S120	Gastric bypass or partition, for morbid obesity		7	619.90	10

Note:
For suture of duodenal ulcer, refer to S139 on next page.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

STOMACH

REPAIR

		Asst	Surg	Anae
# S132	Pyloroplasty	7	406.85	7
# S133	Pyloroplasty and vagotomy	7	528.85	7
# E731	- with suture of bleeding peptic ulcer add		82.35	2
# S137	Pyloroplasty or gastroenterostomy plus vagotomy and cholecystectomy	7	678.90	8
# E731	- with suture of bleeding peptic ulcer add		82.35	2
# E721	- with choledochotomy add		122.05	1
# S134	Gastroduodenostomy or gastrojejunostomy	7	406.85	7
# E716	- either of above plus vagotomy add		147.30	
# E711	- after previous gastroenterostomy add		106.55	
# E721	- with choledochotomy add		122.05	1

SUTURE

		Asst	Surg	Anae
# S138	Closure of gastrostomy or other external fistula of stomach	5	345.85	6
# S139	Gastrorrhaphy (for perforated gastric or duodenal ulcer or wound)	6	359.40	7
# S140	Closure of gastrocolic fistula	7	574.40	7

Note:
For suture of duodenal ulcer, refer to S139 above.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

ENDOSCOPY

Code	Description		Asst	Surg	Anae
# Z560	Duodenoscopy (not to be claimed if Z399 and/or Z400 performed on same patient within 3 months)			92.10	6
# Z749	Subsequent procedure (within three months following previous endoscopic procedure)			72.55	6
# E629	- endoscopic placement of stent in duodenum	add		137.05	
# Z584	Small bowel push enteroscopy			185.15	
Z512	Endoscopy of ileostomy or colostomy, or reduction of obstructed Koch ileostomy			36.80	6
E747	- to cecum	add		34.90	
Z514	- with biopsy			44.55	6
Z580	Endoscopy (using 60 cm. flexible endoscope)		nil	57.70	6

Colonoscopy

Code	Description		Asst	Surg	Anae
Z555	- of sigmoid to descending colon		nil	57.70	6
E740	- to splenic flexure	add	nil	57.70	
E741	- to hepatic flexure	add	nil	34.90	
E747	- to cecum	add	nil	34.90	
E705	- into terminal ileum	add		33.90	
# E630	- endoscopic placement of stent in colon	add		137.05	
E717	- if biopsy and/or coagulation of angiodysplastic lesion(s) (one or more), to Z555 or Z580	add		27.05	
E785	- multiple screening biopsies (> 34 sites) for malignant changes in ulcerative colitis, to Z555 only	add		54.25	
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.)	add		46.30	

Note:
E717 rendered in conjunction with E785 is an insured service payable at nil.

Code	Description		Asst	Surg	Anae
E749	- when Z512, Z555 or Z580 rendered in private office	add		22.35	

Note:
For sigmoidoscopy with rigid scope, see Z535 (Rectum).

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae
# Z513	Hydrostatic - Pneumatic dilatation of colon stricture(s) through colonoscope		107.50	
# Z570	Fulguration of first polyp through colonoscope		49.80	6
# E719	- each additional polyp (maximum of 4) add		24.25	
# Z571	Excision of first polyp greater than or equal to 3mm through colonoscope	nil	150.15	6
# E720	- each additional polyp greater than or equal to 3mm (maximum of 2) add		77.50	
	Excision of obstructive tumour or stricture through colonoscopy			
# Z764	- less than 2 cm.		69.80	
# Z765	- 2 cm or greater		131.75	
# E687	- with laser debulking add		69.80	
# E685	- total excision of very large sessile polyp (> 3 cm) through colonoscope, and may include fulguration, each add		227.65	

Note:
Z570 payable at nil if claimed with E685 or Z571 for same polyp.

INCISION

Enterotomy

		Asst	Surg	Anae
# S149	Ileostomy	6	406.85	7
# S150	Small intestine - including excision of polyps or biopsy	6	406.85	7
# S151	Insertion of feeding enterostomy	6	356.50	7
# E737	- when done with another intra-abdominal procedure . add		82.35	
# S154	Large intestine - including excision of polyps	6	406.85	7
# S155	Colonoscopy with laparotomy	6	387.40	7
# S156	Exteriorization of intestine (Mickulicz)	6	406.85	6
# S157	Colostomy	6	406.85	6
# S158	Cecostomy	6	387.40	6
# S160	Entero-enterostomy	6	406.85	7

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae
	EXCISION			
# E714	- repair of entero-cutaneous fistula in conjunction with bowel resection .... add		82.35	
# E793	- laparoscopic or laparoscopic assisted, to S091 or S092 .... add 25%			
# S162	Local excision of lesion of intestine	6	528.85	7
# Z750	Resection of exteriorized intestine	6	82.35	6
	Resection with anastomosis			
	Small intestine			
# S164	- duodenum	6	746.10	7
# S165	- other	6	687.55	7
# S166	Small and large intestine terminal ileum, cecum and ascending colon (right hemicolectomy)	7	799.55	7
# S167	Large intestine - any portion	7	799.55	7
# E796	- with mobilization of splenic flexure, to S167 .... add		102.40	
# S169	Total colectomy with ileo-rectal anastomosis	9	1242.90	9
# S172	Total colectomy with mucosal proctectomy with ileal pouch, ileoanal anastomosis and loop ileostomy	9	2247.70	10
# S171	Left hemicolectomy with anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection & mobilization of splenic flexure)	7	1082.95	8
# E793	- laparoscopic or laparoscopic assisted, to S166, S167, S169 or S171 .... add 25%			
	Ileostomy			
# S168	- subtotal colectomy	7	1057.70	7
# S170	- plus total colectomy plus abdomino-perineal resection	9	1492.15	10
	Two-surgeon team			
# S173	- abdominal	9	966.70	10
# S174	- perineal		284.75	
# E738	- with continent ileostomy, to either S168, S169, S170, S173 or S174 .... add		387.40	
E718	- bowel resection following previous resection with anastomosis, or following S217, S213, S214 or S215 .... add		142.40	

Note:
E718 is not to be added to S218, S181, S182, S185, S191, S192 or S193.

# S188	Bowel resection without anastomosis (colostomy and mucous fistula)	6	544.35	6
# S189	Intestinal bypass for morbid obesity	7	600.60	10

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae
	Intestinal obstruction (mechanical)			
	One stage			
# S175	- without resection	6	452.35	6
# S176	- with entero-enterostomy	6	574.40	7
# S177	- with resection	6	660.50	7
# S180	- with enterotomy	6	518.20	7
	Note: If staged procedure, refer to Surgical Preamble SP3.			
# S178	Intestinal atresia (newborn)	6	682.90	7
# S179	Meconium ileus	6	682.90	7
	REPAIR			
	Revision of ileostomy or colostomy			
# S181	- skin level	5	131.75	6
# S182	- full thickness	6	350.65	6
# S192	Simple revision of continent ileostomy pouch	6	387.40	6
# S191	Complete reconstruction of continent ileostomy to include valve repair	6	951.20	7
# S193	Revision of standard ileostomy into continent ileostomy pouch	6	793.50	7
# S183	Cecopexy or sigmoidopexy (as sole procedure)	5	314.80	6
	SUTURE			
# S184	Suture of intestine	6	314.80	6
# E721	- with choledochotomy add		122.05	1
# S185	Closure of colostomy or enterostomy - with or without resection and/or anastomosis	6	406.85	7
# S187	Plication of small intestine for adhesions	6	528.85	7
	Note: For division or removal of adhesions only, use S312.			
	MANIPULATION			
# Z538	Reduction of prolapse		25.25	6
# Z539	Dilation of gastrostomy, enterostomy, colostomy, etc.		25.25	6
	Intubation of small intestine (therapeutic or diagnostic)			
# Z540	- with or without fluoroscopy		63.85	
# E732	- with biopsy add		29.10	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

MISCELLANEOUS

MECKEL'S DIVERTICULUM

		Asst	Surg	Anae
# S194	Meckel's diverticulum excision	5	356.50	6
# S159	- with small bowel resection	6	406.85	7

MESENTERY

		Asst	Surg	Anae
# S195	Local excision of lesion	5	305.05	6
# S199	Resection of mesentery	5	325.40	6

APPENDIX

		Asst	Surg	Anae
# S204	Incision and drainage of abscess	5	239.20	6
# S205	Appendectomy	5	253.80	6
# S206	- with gross perforation and peritonitis	5	356.50	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

ENDOSCOPY

Sigmoidoscopy with or without anoscopy

		Asst	Surg	Anae
Z535	- with rigid scope		36.80	6
Z536	- with biopsy(ies)		44.55	6
Z592	- with decompression of volvulus		49.40	6
E746	- when Z535, Z536 or Z592 performed outside hospital ... add		5.85	
# E641	- endoscopic placement of stent in rectum ... add		137.05	
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.) ... add		46.30	

Note:
Z535 not to be billed with Z555 or Z580.

EXCISION

Proctectomy

		Asst	Surg	Anae
# S213	Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	8	776.80	8
# S214	Abdomino-perineal resection or pull through	8	935.75	10

Two surgeon team

		Asst	Surg	Anae
# S215	- abdominal surgeon	8	776.80	10
# S216	- perineal surgeon		284.75	
# S217	Hartmann procedure	8	650.90	9
# S218	Colon reconstruction following Hartmann procedure	8	763.30	8
# Z752	Biopsy of rectosigmoid or above for Hirschsprung's disease	5	82.35	6
# E710	- each additional biopsy ... add		45.55	
# S222	Presacral or trans-sacral proctotomy and excision of lesion	5	350.65	6

Polyps or tumours of rectum or sigmoid *

		Asst	Surg	Anae
# Z753	- electrocoagulation - base under 2 cm		24.25	6
# Z754	- excision - base under 2 cm	5	82.35	6
# Z784	- excision and suture - base 2 to 5 cm, inclusive	5	213.50	6
# Z785	- excision and suture - base over 5 cm	5	329.65	6
# Z755	- electrocoagulation - base 2 to 5 cm, inclusive	5	142.40	6
# Z761	- electrocoagulation - base over 5 cm	5	219.90	6
# E688	- with laser debulking ... add		69.80	

Note:

1. * To a maximum of 2, any size or technique.
2. For fulguration or excision of tumours through the colonoscope, use codes Z570, Z571 (page S13).

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

		Asst	Surg	Anae
	REPAIR			
# S223	Anastomosis of rectum	5	488.20	6
	Rectal prolapse			
# S225	- excision of mucous membrane	5	239.20	6
# S226	- perineal repair - major	5	356.50	6
# S227	- abdominal approach	6	554.10	8
# S228	- insertion of Thiersh wire	5	190.85	6
	SUTURE			
# S229	Suture of rectum, trauma-external approach	5	239.20	6
	Closure of fistula			
# S231	- rectovaginal (any repair)	5	338.55	6
# S525	- rectovesical	5	446.90	6
	MANIPULATION			
# Z541	Dilation and/or disimpaction or removal of foreign body under general anaesthetic (as sole procedure)		58.15	6
# Z756	Fecal disimpaction - no anaesthetic		36.80	

Note:
The fees for excision, ligation, injection of haemorrhoids and treatment of intra or perianal condylomata acuminata include anoscopy.

	ENDOSCOPY			
Z543	Anoscopy (proctoscopy)		6.25	
	INCISION			
# Z544	Biopsy		34.90	6
Z545	Thrombosed haemorrhoid(s)		25.25	6
E542	- when performed outside hospital add		11.15	
# S241	Sphincterotomy(ies)	5	88.20	6
# S242	- with excision of fissure(s)	5	162.70	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

EXCISION

		Asst	Surg	Anae
# S246	Excision of fissure(s)	5	122.05	6
# S247	Haemorrhoidectomy, with or without sigmoidoscopy or repair of fissure(s) and/or sphincterotomy and/or anal dilation	5	224.25	6
# Z565	Complete haemorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation		94.85	6
# Z546	Barron ligation(s) (not to exceed 6 in any one year)	nil	27.05	
# Z566	Barron ligation(s) plus cryotherapy (not to exceed 6 in any one year)	nil	34.90	
# S249	Local excision for malignancy	5	153.05	6
Z757	Excision of benign anal lesion(s)	5	40.65	6
E542	- when performed outside hospital add		11.15	
# S251	Fistula-in-ano	5	213.15	6

INJECTION

		Asst	Surg	Anae
Z575	Haemorrhoid injections (to a maximum of 6 per year)		27.05	
Z576	Injections for anal fissure		35.90	6

REPAIR

		Asst	Surg	Anae
# S253	Low imperforate anus repair	7	406.85	7
# S260	High imperforate anus repair (supra-levator)	7	900.75	7
# S256	Excision of scar, for stenosis	5	142.40	6
# S257	Anoplasty, for stenosis	5	275.05	6
# S258	Repair of anal sphincter	5	275.05	6
# S259	Repair of anal sphincter and ano-rectal ring	5	356.50	6

DESTRUCTION

		Asst	Surg	Anae
Z548	Cauterization of fissure		34.90	6

Fulguration of condylomata

		Asst	Surg	Anae
Z549	- local anaesthetic		30.95	
# Z758	- general anaesthetic	5	84.20	6

MANIPULATION

		Asst	Surg	Anae
Z550	Dilation of anal sphincter		12.05	6
# S248	Peter Lord procedure		43.60	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

LIVER

		Asst	Surg	Anae
	INCISION			
	Biopsy			
# Z554	- incisional		82.35	
# Z551	- needle		70.80	6
# S268	Insertion of implantable pump for continuous liver perfusion	7	604.95	7
	EXCISION			
	Hepatectomy			
# S269	- local excision of lesion (less than 5 cm)	7	350.65	7
# S275	- partial lobectomy (excision greater than 5 cm)	8	585.05	8
	Formal anatomical resection			
# S270	- one or two liver segments	12	1184.60	12
# S267	- three or four liver segments	12	1652.15	12
# S271	- five or more liver segments	12	1784.60	12
# S272	Laparotomy, cholangiogram and biopsy (neonatal jaundice)	6	387.40	6
	Liver transplant			
# E765	- with reconstruction or repair of the hepatic artery (i.e. re-anastomosis or conduit), to liver transplant fee ... add		300.45	
# S274	- donor	6	964.50	8
# S294	- recipient	20	2748.75	30
# S295	Repeat liver transplant	30	3776.20	40

Note:
Cholecystectomy is not eligible for payment when claimed with liver lobectomy.

		Asst	Surg	Anae
	REPAIR			
# S273	Marsupialization and/or decompression of cyst(s) or abscess(es)	7	350.65	7
# E715	- more than three cysts or abscess(es) ... add		74.90	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

BILIARY TRACT

Note:
Unless otherwise specified, there is no additional fee payable for cholangiogram during abdominal surgery.

ENDOSCOPY

Endoscopic retrograde cholangiopancreatography (ERCP)

			Asst	Surg	Anae
# Z561	- with cannulation of common bile duct and or pancreatic duct			213.15	6
# Z558	- including sphincterotomy and may include removal of one or more bile duct stones			300.25	6
# Z760	- through gastrojejunostomy following previous Billroth II			251.85	6
# E702	- with multiple (3 or more) biopsies of a specific lesion	add		15.10	
# E666	- with biliary tract manometry	add		52.30	
# E662	- with intraductal cytology brushing or intraductal biopsy	add		49.75	
# E668	- with cannulation of minor papilla	add		93.80	
# E680	- with insertion of first endobiliary prosthesis and/or pancreatic stent (maximum 1)	add		82.35	
# E681	- with insertion of each additional endobiliary prosthesis and/or pancreatic stent (maximum 3)	add		43.60	
# E669	- with oesophagoscopy-gastroscopy and may include duodenoscopy	add		102.75	

Note:
E662, E666, E668, E702, E680, E681, E669 are payable with Z561, Z558 or Z760.

			Asst	Surg	Anae
# Z593	Nasobiliary catheter insertion			55.25	

INCISION

			Asst	Surg	Anae
# S233	Percutaneous trans-hepatic catheter drainage of obstructed bile ducts including daily supervision and including percutaneous cholangiogram and catheterization to duodenum if achieved			317.95	
# S234	- replacement of catheter in above	add		52.30	

Biliary duct calculus manipulation and/or removal via T-tube tract

			Asst	Surg	Anae
# Z562	- as sole procedure			116.20	7
# Z542	Intubation of bile duct for obstruction			68.75	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

BILIARY TRACT

INCISION

		Asst	Surg	Anae
# S278	Cholecystostomy	7	370.95	7
# S276	Choledochotomy (previous cholecystectomy)	7	610.20	8
# S280	Transduodenal sphincterotomy and choledochotomy (previous cholecystectomy)	7	844.65	9
# S281	Choledochoduodenostomy or choledochoenterostomy or choledochocholechostomy	7	721.70	9
# E704	- with choledochoscopy, to S276, S280, S281, or S287 plus E721 add		46.50	

Note:
S281 cannot be claimed with S276.

		Asst	Surg	Anae
# S282	Cholecystogastrostomy	7	447.45	7
# S283	Cholecystoenterostomy	7	447.45	7
# E743	- with entero-enterostomy, to S281 or S283 add		153.05	
# S285	Intrahepatic choledochoenterostomy (anastomosis above the common hepatic duct bifurcation)	9	915.30	12

EXCISION

		Asst	Surg	Anae
# S287	Cholecystectomy	7	455.25	7
# E721	- with choledochotomy add		122.05	1
# E722	- with transduodenal sphincterotomy add		162.70	1
# E728	- with truncal or selective vagotomy add		167.65	
# E729	- with highly selective vagotomy add		284.75	
# E794	- with intra-operative cholangiogram, to S287 add		35.85	
# S291	Choledochectomy for tumour*	8	406.85	8

REPAIR

		Asst	Surg	Anae
# S292	Common duct stricture, dissection and/or resection*	7	203.40	10
# S293	Biliary duct atresia, infant (see General Preamble GP12)	8	I.C	12
# Z596	Extracorporeal shock wave lithotripsy for bile duct calculi		314.20	6

Note:
* For reconstruction, refer to S281.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ABDOMEN, PERITONEUM, AND OMENTUM

PARACENTESIS

Aspiration

			Asst	Surg	Anae
Z590	- for diagnostic sample			25.25	
Z591	- with therapeutic drainage with or without diagnostic sample			46.50	6
E724	- administration of chemotherapy or sclerosing agent	add		23.25	
Z763	Paracentesis with lavage for diagnosis			38.70	6
E542	- when performed outside hospital, to Z590, Z591 or Z763	add		11.15	

INCISION

			Asst	Surg	Anae
# Z563	Needle biopsy of peritoneum			38.70	
# Z564	Open lavage of peritoneal cavity for diagnosis without manual exploration of peritoneal cavity			73.60	6
# S312	Laparotomy, with or without biopsy or for Hirschsprung's disease (except biopsies of stomach, liver, pancreas and multiple para-aortic lymph nodes)		6	305.05	6

Note:

1. S312 - use for division or removal of adhesions, if no other abdominal surgery performed - may not be claimed with other intra-abdominal procedures (except for IOP).
2. Omentectomy for tumour debulking - professional assessment by the Ministry of Health and Long-Term Care Medical Consultant is available and may be requested.

			Asst	Surg	Anae
# E745	- insertion of tubes and post-operative continuous peritoneal lavage when combined with any other abdominal procedure	add		94.85	

Laparotomy

			Asst	Surg	Anae
# S321	- for acute trauma		6	397.15	6
# E733	- with repair of intestine - single	add		142.40	3
# E734	- multiple and/or with resection	add		211.15	3
# E735	- with splenectomy (partial or complete)	add	4	284.75	3
# E736	- with repair of lacerated liver	add	4	187.90	3
# E739	- with repair of diaphragm	add	4	122.05	2
# E723	- with repair of lacerated spleen	add	4	284.80	3
# E693	- with repair of ruptured bladder	add	4	-	3
# E694	- with nephrectomy	add	4	-	3

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ABDOMEN, PERITONEUM AND OMENTUM

INCISION

Code	Procedure		Asst	Surg	Anae
	Peritoneal abscess				
# S313	- subphrenic		7	370.95	7
# S314	- abdominal		6	264.45	6
# Z569	Pelvic abscess, incision and drainage - rectal or vaginal approach			122.05	6
# Z594	Percutaneous abdominal abscess drainage including daily supervision, for one or more abscesses within the same abdominal quadrant or the pelvis			232.50	
# E686	- within each other abdominal quadrant, or the pelvis (if the initial abscess was not in the pelvis)	add		116.20	
Z595	- replacement of drainage catheter in abdominal abscess	add		43.60	
# Z574	Removal of infected sutures from abdominal wall or re-exploration of wound for bleeding - general anaesthetic		5	94.85	6
# S311	Umbilical vein intra-abdominal dissection and catheterization		6	232.50	6

Note:
For vascular newborn - see Diagnostic & Therapeutic Procedures - Vascular Cannulation.

Code	Procedure		Asst	Surg	Anae
# S320	Insertion of antabuse into abdominal wall			58.15	
	Insertion of peritoneo-jugular shunt for ascites				
# S203	- primary		7	281.85	7
# S209	- revision		7	208.15	7

EXCISION

Code	Procedure		Asst	Surg	Anae
# S316	Excision of full thickness abdominal wall tumour and primary closure (see General Preamble GP12)			I.C	6
# S317	Umbilectomy - plastic		5	111.45	6
	Panniculectomy				
# S318	- includes any necessary diastasis repair		6	435.90	6
# E748	- with repair of umbilical hernia	add		122.05	
# S319	Mesenteric cyst		6	335.15	6

Note:
S318 Panniculectomy requires Ministry of Health and Long-Term Care authorization (see Surgical Preamble SP4).

ENDOSCOPY

Code	Procedure		Asst	Surg	Anae
	Peritoneoscopy, culdoscopy or laparoscopy				
# Z552	- without biopsy		5	131.45	6
# Z553	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants		5	173.25	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ABDOMEN, PERITONEUM AND OMENTUM

Code	Procedure		Asst	Surg	Anae
	REPAIR				
# S325	Omentopexy - as sole operative procedure		6	305.05	6
	Herniotomy				
	Inguinal and/or femoral				
# S322	- infants		5	284.75	6
# S326	- children		5	251.20	6
# S323	- adolescents and adults		5	284.75	6
	Unilateral with exploration of other side				
# S328	- infants and children		5	329.30	6
	Strangulated or incarcerated				
# S329	- without resection of bowel		5	366.15	6
# S330	- with resection of bowel		6	660.50	7
	Umbilical				
# S332	- adolescent or adult		5	284.75	6
# S333	- child (operative)		5	222.75	6
# E764	- umbilical hernia repair when done in conjunction with other abdominal surgery, to other surgery	add		96.85	
# E756	- with resection of strangulated contents	add		111.45	2
# E757	- without resection of strangulated contents	add		55.25	1
	Omphalocele and gastroschisis				
# S334	One stage - repair		7	375.80	7
	Multiple staged - repair				
# S335	- gross method or Silon mesh		7	370.95	7
# S336	- second stage repair (completion of abdominal wall closure)		7	370.95	7
	Diaphragmatic other than oesophageal hernia				
	One stage procedure				
# S337	- trans-abdominal		7	508.55	9
# S338	- trans-thoracic		9	508.55	13
# S339	- second stage and abdominal closure		5	295.40	9
# S340	Ventral - post-operative		6	370.95	6
# S344	Massive incisional hernia		6	416.50	6
# S345	Massive sliding inguinal hernia		6	350.65	6
# E725	- recurrent - all types, except oesophageal	add	4	87.15	2
# E726	- repeat recurrent inguinal hernia (more than 2 repairs), to S322, S323, S326, S329, S330	add	4	152.10	2
# S342	Epigastric		5	239.20	6
# E727	- hydrocele - extra - applicable to adults only	add		65.90	
	SUTURE				
# S343	Secondary closure for evisceration - sole operative procedure in abdomen		6	275.05	6

NOT ALLOCATED

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND PERINEPHRIUM

PREAMBLE

1. No additional claim should be made for nephroscopy when done at the time of pyelolithotomy or nephrolithotomy. This does not apply to nephroscopy done in conjunction with codes listed under "Percutaneous - Procedures."
2. In a routine surgical approach to the kidney and related procedures, no additional claim should be made for rib resection carried out for access purposes.
3. When an adrenalectomy is performed in conjunction with a nephrectomy, and is incidental to the removal of the kidney, there should be no additional claim for the adrenalectomy.

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND PERINEPHRIUM

			Asst	Surg	Anae
# E752	- with repeat surgery on kidney at least 30 days after previous kidney surgery	add		83.25	
	INCISION				
# Z601	Renal biopsy, needle			100.65	6
# S401	Drainage of kidney abscess		7	331.70	7
# S402	Drainage of perinephric abscess		7	215.80	7
# S403	Exploration of renal and peri-renal tissues (with or without biopsy or unroofing of cyst)		7	356.70	7
	Nephrotomy				
# S404	- with drainage - nephrostomy - when sole operative procedure on kidney		7	356.70	7
# E763	- when done in conjunction with other non renal procedure(s)	add		150.50	
# S405	- with removal of calculus		7	482.40	7
# Z600	- change of nephrostomy tube			35.50	
# S406	Transection of aberrant renal vessels - when sole operative procedure		7	381.60	7
	Pyelotomy				
# S407	- with drainage		7	381.60	7
# S408	- with removal of calculus		7	437.20	7
# S409	- with diversion of urine		7	467.00	7

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND PERINEPHRIUM

EXCISION

		Asst	Surg	Anae
# S410	Calycectomy with diversion of urine	7	512.00	7
# S411	Partial or heminephrectomy	7	697.95	7
# E792	- when performed laparoscopically, to S411 add 25%			
# S423	Partial or heminephrectomy with total ureterectomy	7	757.85	7

Nephrectomy

		Asst	Surg	Anae
# S412	- ectopic kidney	7	467.00	7
# S413	- lumbar	7	467.00	7
# E792	- when performed laparoscopically, to S413 add 25%			
# S415	- transperitoneal	7	522.50	7
# S416	- thoraco-abdominal or radical nephrectomy	9	875.00	13
# E766	- with gland dissection add		29.70	
# E767	- with repair of vena cava for thrombus - below the hepatic vein add		138.15	
# E768	- with repair of vena cava for thrombus - above the hepatic vein add		236.70	
# E792	- when performed laparoscopically, to S416 add 25%			
# S424	Extrophy - plastic closure of bladder with closure of abdominal wall and urethral lengthening with closure of pelvic floor with or without reimplantation of ureters	7	939.70	10
# S420	Nephroureterectomy, total, with resection of ureterovesical junction	7	592.55	10
# S421	Excision of stenosed renal artery with reimplantation or homograft	7	788.15	6

REPAIR

		Asst	Surg	Anae
# S422	Pyeloplasty (with or without nephropexy)	7	522.50	7
# E754	- with removal of calculus add		57.50	
# S426	Nephropexy - when sole operative procedure	7	381.60	7
# S428	Symphysiotomy for horseshoe kidney with or without nephropexy and associated procedures	7	437.20	7

SUTURE

		Asst	Surg	Anae
# S429	Ruptured or lacerated kidney - repair or removal	7	437.20	7
# S430	Removal of staghorn calculus filling renal pelvis and calyces to include x-ray control	7	657.75	9

EXTRA RENAL PROCEDURES

		Asst	Surg	Anae
# S431	Excision of retroperitoneal tumour	7	381.60	7
# S432	Exploration of retroperitoneal tumour	7	260.85	7
# S433	Sacrococcygeal teratoma	6	437.20	6
# Z630	Extracorporeal shock wave lithotripsy		314.20	6

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND PERINEPHRIUM

PERCUTANEOUS PROCEDURES

			Asst	Surg	Anae
# Z629	Percutaneous nephrostomy			153.35	6
# Z623	Insertion of stent			76.70	
# Z624	Dilatation of tract			95.95	
# Z625	Selective catheterization of calyces (one or more)			52.70	
# Z626	Nephroscopy			95.95	6
# Z627	Removal of renal calculi		5	167.85	6
# E759	- if disintegrated by ultrasound	add		95.95	
# E772	- percutaneous removal of staghorn calculus filling renal pelvis and extending into calyces	add		175.50	
# Z636	Percutaneous endopyelotomy for ureteropelvic junction obstruction, primary or secondary			273.25	6
# Z637	Percutaneous ablation of calyceal diverticulum to include dilation of communication with calyx and fulguration			262.75	6

RENAL TRANSPLANTATION PROCEDURES

Note:

Submit on recipient's claim. These fees do not include immunosuppressive therapy which is on a fee-for-service basis.

			Asst	Surg	Anae
# E762	- reconstruction or repair of renal artery done in addition to renal transplantation procedures	add		301.05	
# S435	Kidney transplant		9	1553.15	1[illegible]
# E769	- team fee (not to be billed when assistant fees are billed)	add		260.05	
# S434	Kidney re-transplant		9	1858.15	13
# E771	- team fee (not to be billed when assistant fees are billed)	add		343.40	
# S436	Donor nephrectomy - unilateral or bilateral (to include renal perfusion with hypothermia when rendered by surgeon)		7	653.20	8
# E753	- live donor	add		156.30	
# E792	- when performed laparoscopically, to S436	add 25%			

Note:

For nephrological components - see Diagnostic and Therapeutic Procedures.

			Asst	Surg	Anae
# S437	Renal autotransplantation		7	1161.60	10
# Z631	Fine needle aspiration of renal transplant			36.40	

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND PERINEPHRIUM

Code	Procedure		Asst	Surg	Anae
	ENDOSCOPIC PROCEDURES				
# S470	Cystoscopy with manipulation and/or removal of calculus and retrograde pyelogram if required			240.65	6
	Cystoscopy and diagnostic Ureteroscopy				
# Z628	- above intramural			125.65	6
# E819	- diagnostic ureteroscopy of second ureter, to Z628	add		54.65	
# E822	- ureteroscopy to upper third of ureter or renal pelvis, to Z628	add		37.70	
# E760	- with removal of calculus	add		167.85	
# E761	- intracorporeal lithotripsy by any method	add		95.95	
# E820	- with biopsy of one or more sites in ureter and/or pelvis using ureteroscope	add		49.75	
# E823	- resection and fulgarization of one or more ureteral or renal pelvic tumours, to Z628	add		233.65	
	INCISION				
# S442	Periureteral abscess		6	215.80	6
	Ureterotomy, abdominal or vaginal exploratory or for drainage				
# S443	- upper 2/3		6	260.85	6
# S444	- lower 1/3		6	381.60	6
	With removal of calculus				
# S445	- upper 2/3		6	376.80	6
# S446	- lower 1/3		6	482.40	6
	Where ureter has been previously opened				
# S447	- upper 2/3		6	437.20	6
# S448	- lower 1/3		6	522.50	6
	EXCISION				
	Ureterectomy				
# S449	- including ureterovesical junction		6	437.20	7
# S450	- other e.g. partial		6	331.70	7

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND PERINEPHRIUM

		Asst	Surg	Anae
	REPAIR			
# S451	Ureterovesical anastomosis or re-implantation unilateral	6	437.20	8
	Note: Not to be billed in addition to S482.			
# S561	Re-implantation of ureter with extensive tapering with or without ureterolysis	6	657.75	8
# S562	Bifid ureter	6	482.40	8
# S452	Ureteroileal conduit	6	788.15	9
# S453	- with total cystectomy	9	1250.30	15
# S454	- with ureterectomy and ileal replacement	6	893.50	9
	Ureterointestinal anastomosis or transplant			
# S455	- unilateral	6	331.70	6
# S462	- bilateral	6	438.35	6
# S456	- bilateral with cystectomy, one stage	9	984.65	13
# S457	Ureteroureterostomy	6	552.30	8
	Ureterostomy			
	Cutaneous			
# S458	- unilateral	6	260.85	6
# S463	- with lower third ureterotomy	6	381.60	6
# S459	Ureterovaginal fistula	6	557.85	6
	Ureterolysis for periureteral fibrosis			
# S460	- unilateral	6	437.20	6
	Note: When a physician submits a claim for performing any insured surgical procedure on the same patient on the same day as the physician submits a claim for rendering S460, the S460 service is included (in addition to the common elements) as a specific element of that other insured service.			
	Ureteroplasty (Hutch)			
# S461	- unilateral	6	331.70	6
	Bladder flap (Baori)			
# S427	- to include reimplantation of ureter	6	502.45	6
	SUTURE			
	Spontaneous or traumatic rupture or transection			
	Immediate			
# S465	- upper 2/3	6	381.60	6
# S466	- lower 1/3	6	437.20	6
	Late repair			
# S467	- upper 2/3	6	437.20	6
# S468	- lower 1/3	6	482.40	7

UROGENITAL AND URINARY SURGICAL PROCEDURES

PREAMBLE

1. No extra claim should be made for EUA when done at the time of cystoscopy.
2. Visit fees, as applicable, to be claimed for changing a suprapubic tube.
3. No claim should be made for pre-cystoscopy dilatation of the male urethra unless urethral stricture is the primary diagnosis. No claim should be made for dilatation of the female urethra when done at the same time as cystoscopy.
4. "E" prefixed codes are payable in addition to any "S" or "Z" code listed under the "Bladder" subheading or to Z628.

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

ENDOSCOPY - CYSTOSCOPY

Diagnostic Procedures

		Asst	Surg	Anae
# Z606	Diagnostic with or without urethroscopy		71.00	6
# Z607	Repeat within 30 days		35.50	6
# Z635	Balloon dilatation of prostate and bladder neck, to include cystoscopy		130.20	
# E775	- with catheterization of the ureters and collection of the ureteral specimens and/or retrograde injection of opaque media one side ... add		15.35	
# E776	- with any combination of: transurethral biopsy, brush biopsy of renal pelvis and/or ureter or insertion of ureteric stent ... add		24.90	
# E777	- with cystometrogram (to include urethral pressure profile if necessary) ... add		11.50	
# E778	- with meatotomy or internal urethrotomy (female) ... add		8.55	
# E780	- with needle biopsy of prostate ... add		32.60	
# E783	- with secondary surgical evacuation of bladder clots and control of haemorrhage ... add		99.65	
# E784	- with hydrodistention of bladder and/or biopsy - general anaesthetic ... add		49.85	
# E773	- with placement of ureteric stent past obstructing calculus (unilateral) ... add		49.90	
# E791	- with periurethral injection of collagen or polytetrafluoroethylene (PTFE) ... add		26.00	

Therapeutic Procedures

		Asst	Surg	Anae
# E781	- with electrocoagulation - tumour(s) ... add		49.90	
# E782	- with electrocoagulation - Hunner ulcer ... add		49.90	
# E786	- with resection bladder neck, female ... add		99.70	
# E787	- with resection bladder neck, male ... add		260.40	1
# E788	- with electro surgical ureteral meatotomy ... add		99.70	
# E789	- with removal foreign body or calculus ... add		99.70	
# E790	- with removal of ureteric catheter ... add		8.80	
# E751	- with insertion of radioactive substance, in addition to associated procedures ... add		54.70	
	Excision of tumour or tumours including base and adjacent muscles and electrocoagulation if necessary			
# Z632	- single tumour 1 to 2 cm diameter		271.35	6
# Z633	- single tumour over 2 cm diameter		437.20	6
# Z634	- multiple tumours		437.20	6

Note:
No additional claim for cystoscopy when done at the same time as excision of tumour(s).

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

INTRODUCTION

Catheterization

Code	Description	Asst	Surg	Anae
	Acute retention, change of Foley catheter or suprapubic tube or instillation of medication			
Z602	- office		8.55	
Z603	- home		16.25	
# Z611	- hospital		8.55	

Note:
Z611 may not be claimed in conjunction with pelvic or genito-urinary surgery.

Code	Description	Asst	Surg	Anae
Z608	Manual catheter declotting and irrigation of bladder		58.65	

INCISION

Code	Description	Asst	Surg	Anae
Z605	Aspiration		12.50	
# S478	Cystotomy or cystostomy	5	215.80	6
# Z480	Cystotomy with trochar and cannula and insertion of tube		85.30	6
# E750	- when done in conjunction with another procedure . . add		26.05	
# S481	Cystolithotomy - when sole operative procedure	5	260.65	6
# S476	Cutaneous vesicostomy	5	437.20	6
# S477	Reduction cystoplasty (bladder plication)	5	356.70	6

EXCISION

Cystectomy

Code	Description	Asst	Surg	Anae
# S482	- partial for tumour or diverticulum (single or multiple)	6	381.60	6
# S483	- with reimplantation of ureter	6	552.30	7
# S490	- with reimplantation of ureters	6	733.50	7
# S484	- complete cystectomy, without transplant	6	657.75	10
# S485	- with ureterointestinal transplant	8	984.65	13
# S453	- with ureteroileal conduit	9	1250.30	15
# S440	- complete cystectomy with Koch pouch urinary diversion	9	1475.70	15

Note:
S482 not to be billed in addition to S451.

Code	Description	Asst	Surg	Anae
# S441	Creation of Koch pouch urinary diversion	9	1013.45	15
# S471	Excision of urachal cyst or sinus with or without umbilical hernia repair	6	296.30	6
# S487	Excision of urachus, repair of bladder and diversion of urine	6	296.30	6

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

		Asst	Surg	Anae
	EXCISION			
	Extrophy - excision of bladder and repair of abdominal wall			
# S488	- inclusive of graft	6	215.80	6
# S489	- above including bilateral ureterosigmoidostomy	6	657.75	6
# S491	Plastic repair of extrophy using bladder and including skin flaps	6	657.75	6
	REPAIR			
# S512	Repair of ruptured bladder	5	330.90	6
# S513	Cystoplasty, using intestine	8	657.75	9
	Plastic repair of bladder neck			
# S518	- child	5	331.70	6
# S519	- adolescent or adult	5	437.20	6
# S520	- with diverticulectomy	5	552.30	7
	DESTRUCTION			
# S521	Litholapaxy and removal of fragments		215.80	6
	SUTURE			
	Closure of fistula			
# S522	External, suprapubic	5	260.85	6
	Vesicovaginal			
# S523	- vaginal approach	5	435.20	6
# S524	- transvesical approach (with or without omental flap)	5	467.00	6
# S525	Vesicorectal or vesicosigmoid	5	446.90	6

Note:
Closure of fistula see also S734, S711 Operations on the Female Genital System.

UROGENITAL AND URINARY SURGICAL PROCEDURES

URETHRA

ENDOSCOPY

Urethroscopy

Code	Procedure	Asst	Surg	Anae
# Z617	- diagnostic		35.50	6
# Z618	- with biopsy		77.70	6
# S547	Removal of foreign body or calculus		170.65	6

INCISION

Code	Procedure	Asst	Surg	Anae
# Z616	Biopsy of urethra (without endoscopy)		23.55	6

Urethrotomy

Code	Procedure	Asst	Surg	Anae
# S530	- external	5	215.80	6
# S532	- transurethral (visual)	5	166.05	6
# S538	- repeat procedure within 6 months by same surgeon	5	95.75	6
# S531	Urethrostomy	5	215.80	6
# Z604	Meatotomy and plastic repair		31.60	6
# S533	For extravasation of urine with multiple drainage	5	215.80	6
# S534	- above with external urethrotomy or cystotomy	5	331.70	6
# Z609	Periurethral abscess		31.60	6

EXCISION

Code	Procedure	Asst	Surg	Anae
# S536	Caruncle	5	85.30	6
# S537	Urethral papilloma, single or multiple		85.30	6
# S541	Diverticulectomy - male or female	5	260.85	6
# S542	Posterior urethral valve	5	331.70	6
# S543	Prolapse urethra	5	85.30	6
# S544	Urethrectomy - radical	5	215.80	6

REPAIR

Code	Procedure	Asst	Surg	Anae
# S548	Urethral sling	5	381.60	6

Retropubic urethropexy for stress incontinence

Code	Procedure	Asst	Surg	Anae
# S549	- primary procedure	5	301.35	6
# S546	- repeat procedure for failed retropubic or vaginal surgery for stress incontinence	5	353.90	6

Note:
See also S731-S733, Operations on the Female Genital System for stress incontinence.

Code	Procedure	Asst	Surg	Anae
# S559	Prosthetic procedure for urinary incontinence (e.g. Kauffman, Rosen type etc.)	5	381.60	6
# S560	- where perineum has been previously operated on for incontinence	5	437.20	6
# S563	Removal of perineal incontinence prosthesis	5	143.75	6

UROGENITAL AND URINARY SURGICAL PROCEDURES

URETHRA

		Asst	Surg	Anae
	REPAIR			
# S539	Insertion of inflatable prosthesis at bladder neck with or without urodynamic control	5	776.70	6
# S540	Revision or removal of inflatable prosthesis at bladder neck	5	239.75	6
	Urethroplasty			
	First stage			
# S545	- posterior	5	381.60	6
# S550	- anterior	5	293.35	6
# S558	Second stage	5	235.35	6
# S535	One stage repair and may include skin grafting	5	381.60	6
	SUTURE			
# S551	Rupture, anterior urethra (diversion of urine extra)	5	170.65	6
	Posterior urethra			
# S552	- immediate repair	5	437.20	6
# S553	- late repair	5	552.30	6
	Fistula			
# S554	- penile urethra (diversion of urine extra)		92.10	6
# S555	- perineal urethra	5	325.95	6
# S556	Rectourethral with diversion, colostomy and closure of colostomy	6	552.30	7
	DESTRUCTION			
# S557	Urethrovesicolysis - when sole operative procedure	5	215.80	6
# S564	Transurethral incision or resection of external sphincter - when sole operative procedure		325.95	6
	MANIPULATION			
	Dilatation of stricture			
Z621	- male, local anaesthetic		13.65	
# Z619	- male, general anaesthetic		52.70	6
	Dilatation of urethra			
Z622	- female		5.65	
# Z620	- female, general anaesthetic		41.65	6
# Z615	Filiform and follower urethral dilation and may include bladder catheterization		59.75	6

Note:
Z619, Z620, Z621, Z622 payable at nil if claimed with Z615.

MALE GENITAL SURGICAL PROCEDURES

PENIS

INCISION

Slit of prepuce (complete care)

		Asst	Surg	Anae
# S567	- newborn		14.35	
# S568	- infant		21.50	6
# S569	- adult or child		30.25	6

EXCISION

Circumcision - for physical symptomatology only

		Asst	Surg	Anae
# S573	- for patients aged one year or older	5	90.05	6
# S577	- for infants less than one year of age	5	90.05	6

Note:

1. Circumcision is an insured service only when medically necessary. As such, circumcision performed for ritual, cultural, religious or cosmetic reasons at any age is not an insured service.
2. Circumcision for neonatal phimosis is not an insured service.

		Asst	Surg	Anae
Z702	Biopsy		23.55	6
E542	- when performed outside of hospital add		11.15	

Amputation

		Asst	Surg	Anae
# S574	- partial	5	170.65	6
# S575	- partial with inguinal glands 1 or 2 stages	5	437.20	6
# S576	- radical with inguinal and femoral glands 1 or 2 stages	6	552.30	7

Condylomata

		Asst	Surg	Anae
Z701	- local anaesthetic		32.60	
# Z767	- general anaesthetic		78.60	6
# S599	Excision plaque for Peyronies disease	5	210.95	6

Note:
Where grafting is necessary, appropriate skin graft fee is payable with S599.

REPAIR

Hypospadias or Epispadia

		Asst	Surg	Anae
	One stage repair			
# S578	- with meatus to but not into glans	5	287.75	6
# S571	- with advancement of meatus into glans	5	383.50	6
# S572	- into glans using island flap pedicle (penoscrotal)	5	662.45	6
# S579	Chordee repair	5	215.80	6
# S580	Plastic reconstruction, urethra	5	331.70	6
# S581	Closure urethro-cutaneous fistula		92.10	6
# S597	Penile prosthesis for impotence	5	306.85	6
# E755	- with inflatable prosthesis add		55.15	
# S588	Surgical removal of prosthesis	5	110.15	6
# S566	Revision including removal of prosthesis	5	239.75	6
Z700	Intracorporeal injection for impotence		27.80	

MALE GENITAL SURGICAL PROCEDURES

TESTIS

		Asst	Surg	Anae
	INCISION			
# Z703	Abscess		55.15	6
	BIOPSY			
# Z704	Single		55.15	6
# Z705	Bilateral		83.35	6
# Z706	- with vasography		120.80	6

Note:
See also Diagnostic Radiology - GU Tract.

	Orchidectomy			
# S589	- unilateral	5	170.65	6
# S590	Radical removal lymph nodes for testicular tumour	6	834.25	8
	Radical orchidectomy for malignancy			
# S598	- unilateral	5	235.35	6
	REPAIR			
	Orchidopexy			
# S591	- for undescended testis, any type, one or two stages to include hernia repair where required	5	331.70	6
# S592	- second stage (Torek) repair		55.15	6
# S593	Exploration for undescended testicle, without orchidopexy	5	260.85	6
# S600	Reduction of torsion of testis or appendix testis and orchidopexy (one or both sides) if required	5	235.35	6
# S595	Ruptured testicle	5	170.65	6
# S596	Insertion of testicular prosthesis	5	170.65	6

Note:
Insertion of testicular prosthesis performed at the time of orchidectomy is *not eligible for payment.*

[**Commentary**:
See Appendix D - Sub-Surface Pathology under Congenital Deformities and Post-Traumatic Deformities.]

MALE GENITAL SURGICAL PROCEDURES

EPIDIDYMIS AND TUNICA VAGINALIS

		Asst	Surg	Anae
	EPIDIDYMIS			
# Z707	Incision of abscess		55.15	6
# S601	Spermatocele or spermatic granuloma excision	5	170.65	6
	Epididymectomy			
# S602	- unilateral	5	170.65	6
	TUNICA VAGINALIS			
Z708	Hydrocele aspiration		16.25	
# S611	Hydrocele excision - unilateral	5	170.65	6

Note:
Hydrocele excision rendered with hernia repair is claimed as E727

MALE GENITAL SURGICAL PROCEDURES

SCROTUM

INCISION

Abscess or haematocele

		Asst	Surg	Anae
Z709	- local anaesthetic		20.10	
# Z768	- general anaesthetic		55.15	6
# S616	- and exploration - unilateral	5	85.30	6

EXCISION

		Asst	Surg	Anae
# S618	Resection of scrotum	5	215.80	6

SUTURE

Note:
For suture of lacerations, refer to the general listings under Integumentary System Surgical Procedures - Skin and Subcutaneous Tissue - Suture of Lacerations. Where suture of lacerations is the sole procedure and is done under general anaesthesia, refer to code E530.

MALE GENITAL SURGICAL PROCEDURES

VAS DEFERENS

INCISION

		Asst	Surg	Anae
# Z710	Vasography		35.15	6

REPAIR

Vasovasostomy and/or vasoepididymostomy

		Asst	Surg	Anae
# S623	- unilateral	5	215.80	6
S625	- including biopsy and vasography	5	260.85	6

Note:
To include microscopic control if required.

SUTURE

Vasectomy

		Asst	Surg	Anae
S626	- uni - or bilateral - by any technique	nil	107.40	6
E545	- when performed outside hospital add		11.15	

Note:
Vasectomy reversal is an insured benefit only for treatment of significant symptomatology, and requires prior approval. Re-establishing fertility does not constitute significant symptomatology.

MALE GENITAL SURGICAL PROCEDURES

SPERMATIC CORD AND SEMINAL VESICLES

SPERMATIC CORD

		Asst	Surg	Anae
	Hydrocele excision			
# S630	- single	5	170.65	6
	Varicocele excision			
# S631	- single	5	170.65	6

Note:
S630 when done with hernia repair use E727.

SEMINAL VESICLES

		Asst	Surg	Anae
# Z711	Incision of abscess		120.80	6
# S636	Vesiculectomy	5	552.30	6

MALE GENITAL SURGICAL PROCEDURES

PROSTATE

PREAMBLE

A transurethral resection followed within 10 days by a bilateral orchidectomy because of carcinoma of the prostate should be claimed in accordance with paragraph (3) of the Surgical Preamble (SP3).

INCISION

		Asst	Surg	Anae
# Z712	Biopsy, needle		77.70	6
# Z713	- with drainage abscess	5	92.10	6
# S644	Biopsy, perineal, open operation	5	215.80	6

Removal of calculus (with or without biopsy)

		Asst	Surg	Anae
# S642	Perineal	5	437.20	6
# S643	Retropubic	5	437.20	6

EXCISION

Prostatectomy

		Asst	Surg	Anae
# S645	Perineal	6	574.60	6
# S646	Perineal with vesiculectomy	8	875.00	11
	Suprapubic - with or without removal of bladder stones			
# S647	- one stage	5	600.75	6
# S648	- two stages - 1st stage	5	280.50	6
# S649	- two stages - 2nd stage	5	339.15	6
	Retropubic - with or without removal of bladder stones			
# S650	- simple	5	600.75	6
# S651	- radical	5	1008.35	6

Note:
Prostatectomy not to include investigative cystoscopy and may include vasectomy.

		Asst	Surg	Anae
# S652	Staging pelvic lymphadenectomy for prostatic cancer	7	431.20	7
# S653	Laparoscopic radical prostatectomy	8	1411.70	8

BRACHYTHERAPY

		Asst	Surg	Anae
# S640	Stereotactic prostate brachytherapy	5	627.15	6

Note:
Stereotactic prostate brachytherapy includes the following:

1. pre-operative prostate volume study - dose planning, assessment and identification of sites for seed implantation;

and

2. operative procedure (implantation of radioactive seeds into the prostate and includes intraoperative imaging (e.g. ultrasound)).

ENDOSCOPY

Transurethral resection of prostate

		Asst	Surg	Anae
# S655	- and may include cystoscopy, meatotomy, dilatation of stricture, internal urethrotomy or vasectomy		450.60	6
# S654	- for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon		411.20	6
# S656	Transurethral drainage of abscess		85.30	6

MALE GENITAL SURGICAL PROCEDURES

NOT ALLOCATED

FEMALE GENITAL SURGICAL PROCEDURES

PREAMBLE

1. In composite operations such as anterior and posterior repair and D&C or anterior and posterior repair and cauterization of cervix and biopsy, the fee shall be that of the major procedure(s).

2. No fee may be claimed for a D&C if:

   a. it is carried out prior to hysterectomy or ectopic pregnancy;

   or

   b. it is carried out routinely prior to tubal occlusion.

3. When operative procedures Z585 - hysteroscopy with embryo transfer and Z718 - laparoscopy for oocyte retrieval are carried out for In Vitro Fertilization, physicians may obtain from their Ministry of Health and Long-Term Care Medical Consultant the current ministry policy regarding conditions approved for coverage under the Plan.

4. When the laparoscope is used as a means of entrance to perform an intra-abdominal procedure, no extra fee for the laparoscopy may be claimed.

5. When a diagnostic laparoscopy is performed prior to laparotomy, the initial procedure should be claimed as E860.

			Asst	Surg	Anae
# E857	- a D&C may be claimed at 85% when pregnancy termination (S752, S756, S785) is carried out at tubal occlusion. If a D&C is indicated for abnormal uterine bleeding (S754) independent of the tubal occlusion procedure or diagnostic laparoscopy	add		46.00	
# E858	- when operative procedures are carried out for infertility, the fee shall be that of the major procedure. When additional procedure(s) are required, e.g. uterine suspension, oophorocystectomy or myomectomy, may be claimed for each additional procedure	add		70.20	
# E854	- ureterolysis - unilateral - payable in conjunction with major gynaecological operative procedure except S743 or S746 and must include surgical definition of pararectal and paravesical spaces, identification of uterine artery and vein, and mobilization of the pelvic ureter from common iliac vessels to ureterovesical junction	add		108.60	

FEMALE GENITAL SURGICAL PROCEDURES

VULVA AND INTROITUS

		Asst	Surg	Anae
	INCISION			
# S700	Hymenotomy		50.90	6
	Abscess of vulva, Bartholin or Skene's gland - incision and drainage			
Z714	- local anaesthetic		17.30	
E542	- when performed outside hospital add		11.15	
# Z715	- general anaesthetic	5	50.90	6
# Z716	Marsupialization of Bartholin's cyst or abscess	5	71.90	6
# Z717	Perineotomy		17.30	
	EXCISION			
	Biopsy(ies) - when sole procedure			
Z477	- local anaesthetic		17.30	
E542	- when performed outside hospital add		11.15	
# Z475	- general anaesthetic	5	50.90	6
# S707	Hymenectomy (with or without perineotomy)		71.90	6
# S706	Cyst of Bartholin's gland	5	112.00	6
	Condylomata - single or multiple			
	Chemical and/or cryosurgery			
Z733	- one or more		10.55	
	Surgical excision or electrodesiccation or CO_2 laser			
Z736	- local anaesthetic		26.85	
# Z769	- general anaesthetic		115.10	6
	Vulvectomy			
# S703	- simple	5	257.05	6
	- radical			
# S704	- without gland dissection	6	431.45	6
	REPAIR			
# S708	Non-obstetrical injury to vulva and/or vagina, and/or perineum (see General Preamble GP12)		I.C	I.C
# S701	Repair of infibulation - resulting from female genital mutilation		82.15	6

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

ENDOSCOPY

		Asst	Surg	Anae
Z478	Vaginoscopy (premenarchal) with or without medication		50.90	6

Note:
Culdoscopy - see Z552 - Abdomen, Peritoneum and Omentum - Digestive System.

INCISION

		Asst	Surg	Anae
# S712	Culdotomy, drainage or needle puncture		71.90	6
Z728	Incision and drainage of cyst, abscess or haematoma		50.90	6

EXCISION

Biopsy(ies) - when sole procedure

		Asst	Surg	Anae
Z722	- local anaesthetic		17.30	
# Z723	- general anaesthetic		50.90	6
# S715	Excision of cyst(s), or benign tumour(s)	5	123.70	6
# S742	Colpectomy - e.g. for carcinoma	5	349.00	6
# S702	Excision of congenital vaginal septum	5	123.70	6

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
	REPAIR			
# S716	Anterior or posterior repair	5	164.00	6
	Anterior and posterior			
# S717	- repair	5	257.05	6
# S718	- repair of enterocoele and/or vault prolapse	5	349.00	6
	Posterior repair and repair of			
# S719	- enterocoele and/or vault prolapse	5	307.80	6
# S723	- anal sphincter	5	272.40	6
	Anterior repair			
# S720	- with or without posterior repair and repair of uterine prolapse (Fothergill or Watkin's interposition)	5	349.00	6
# S721	Anterior, posterior repair with excision of cervical stump	5	349.00	6
	Post hysterectomy vault prolapse			
# S722	- repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	5	349.00	6
# S812	- repeat - repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	5	453.70	6
	Abdominal approach to vaginal vault prolapse			
# S760	- vaginal sacropexy	5	349.00	6
# S813	- repeat - vaginal sacropexy	5	453.70	6
# S808	Laparoscopic vaginal sacropexy	6	436.25	6
# S761	Combined abdominal/vaginal approach for vaginal vault prolapse	7	431.45	7
# S806	Laparoscopic combined abdominal/vaginal approach for vaginal vault prolapse	6	539.35	6
# S724	Perineorrhaphy (not to be claimed with delivery or other vaginal surgery procedures)	5	122.75	6
# S725	Colpocleisis (LeFort or modification)	5	257.05	6
# S726	Construction of artificial vagina (see General Preamble GP12)	5	I.C	6
	Closure of fistula			
# S523	Vesicovaginal - single surgeon	5	435.20	6
	Vesicovaginal - two surgeons			
# S734	- vaginal surgeon	5	297.25	6
# S711	- abdominal surgeon		297.25	

Note:
S711 - see also S524 - Bladder Procedures

		Asst	Surg	Anae
S231	Rectovaginal (any repair)	5	338.55	6
# S729	Ureterovaginal	6	560.95	6
# S709	Urethrovaginal	5	374.85	6

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
	RETROPUBIC URETHROPEXY			
# S549	Primary procedure	5	301.35	6
# S546	- repeat procedure for failed retropubic or vaginal surgery for stress incontinence	5	353.90	6
# S805	Laparoscopic retropubic urethropexy	6	376.65	6
# S807	Laparoscopic repeat retropubic urethropexy	8	442.30	8
	Combined abdominal-vaginal procedure for stress incontinence (sling procedure)			
	Primary approach			
# S728	One surgeon	7	319.80	7
# E862	- when performed laparoscopically add 25%			
	Two surgeons			
# S730	- vaginal surgeon	7	181.20	7
# E863	- when performed laparoscopically add 10%			
# S740	- abdominal surgeon		250.20	
# E862	- when performed laparoscopically add 25%			
	Following previous failed procedure			
# S731	One surgeon	7	431.45	7
# E862	- when performed laparoscopically add 25%			
	Two surgeons			
# S732	- vaginal surgeon	7	257.05	7
# E863	- when performed laparoscopically add 10%			
# S733	- abdominal surgeon		349.00	
# E862	- when performed laparoscopically add 25%			
	Following two or more failed procedures			
# S748	One surgeon	7	671.20	7
# E862	- when performed laparoscopically add 25%			
	Two surgeons			
# S749	- vaginal surgeon	7	431.45	7
# E863	- when performed laparoscopically add 10%			
# S751	- abdominal surgeon		479.45	
# E862	- when performed laparoscopically add 25%			
# S811	Rectus abdominus myocutaneous neovaginostomy - includes harvest of longitudinal, vertical or transverse rectus abdominus flap(s), formation of vaginal pouch and insertion of vaginal mold	8	829.40	8

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

MANIPULATION

Examination and/or dilatation (may include insertion and/or removal of IUD)

		Asst	Surg	Anae
# Z735	- general anaesthetic - as sole procedure		50.90	6
UVC	Removal of IUD without GA		visit fee	

FEMALE GENITAL SURGICAL PROCEDURES

CERVIX UTERI

ENDOSCOPY

		Asst	Surg	Anae
Z731	Initial investigation of abnormal cytology of vulva and/or vagina or cervix under colposcopic technique (to include biopsies and curetting)		50.90	
Z730	Follow up colposcopy		25.50	

Note:
A screening colposcopy is included in the assessment.

CAUTERIZATION

		Asst	Surg	Anae
UVC	Chemical		visit fee	
Z732	Cryotherapy		17.30	
Z724	Electro		8.55	
# Z725	Dilatation and cauterization under general anaesthesia		50.90	6

CONIZATION

		Asst	Surg	Anae
# Z766	Loop Electrosurgical Excision Procedure (LEEP)		78.00	
# S744	Cervix - cone biopsy - any technique, with or without D&C	5	173.15	6
Z729	Cryoconization, electroconization or CO_2 laser therapy with or without curettage for premalignant lesion (dysplasia or carcinoma in situ), out-patient procedure		38.35	

EXCISION

		Asst	Surg	Anae
Z720	Biopsy - with or without fulguration		17.30	6
# S765	Amputation of cervix	5	173.55	6

Cervical stump

		Asst	Surg	Anae
# S766	- abdominal	6	257.05	6
# S767	- vaginal	5	257.05	6

Note:
Excision of cervical polyp(s) under general anaesthesia, use Z720.

FEMALE GENITAL SURGICAL PROCEDURES

CORPUS UTERI

		Asst	Surg	Anae
	REPAIR			
# S774	Repair of incompetent cervix - not associated with pregnancy	5	142.50	6
	ENDOSCOPY			
	Hysteroscopy			
# Z582	- diagnostic		105.40	6
# Z583	- with uterine biopsy and/or D&C		131.40	6
# Z585	- with cannulization of tube(s), lysis of intrauterine adhesions or embryo transfer		131.40	6
	INCISION OR EXCISION			
# E861	- paracervical block - payable in addition to endometrial sampling, ablation or curettage by same physician in an office - unilateral or bilateral add		9.00	
Z770	Endometrial sampling		29.05	
E542	- when performed outside hospital add		11.15	
# S772	Endometrial ablation by any method		218.65	6
# S773	Endometrial ablation by any method, within one year of previous ablation by same surgeon		153.05	6

Note:
Hysteroscopy (Z582, Z583) is not eligible for payment when rendered with endometrial ablation (S772, S773).

		Asst	Surg	Anae
	Abortion			
UVC	- spontaneous, complete		visit fee	
# S768	- spontaneous, incomplete - including D&C		93.00	6
# S752	- induced - curettage, intra-amniotic injection (complete)		112.40	6
# S785	- induced - intra-amniotic injection (incomplete) followed by curettage, or by any technique after 16 weeks of gestation (only if length of gestation is confirmed by ultrasound)		189.85	6
# S756	- missed abortion, or evacuation of molar pregnancy		112.40	6
# S770	- hysterotomy	6	245.40	6
# S783	- hysterotomy with tubal interruption	6	257.05	6
# S754	Diagnostic curettage (with or without cauterization, biopsy of cervix removal of polyps, Rubin's test or hysterosalpingography)		92.30	6
# S753	Intracavitary application of radium or sealed sources including D&C carried out at same time as application (to include consultation fee) - first application		184.10	6
# S755	- repeat application		92.10	6
# S764	Myomectomy	6	349.00	6
# S810	Laparoscopic vaginal hysterectomy	8	536.40	8

FEMALE GENITAL SURGICAL PROCEDURES

CORPUS UTERI

INCISION OR EXCISION

Hysterectomy - with or without adnexa

		Asst	Surg	Anae
# S757	- total or subtotal - abdominal or vaginal	6	429.10	6
# S758	- with anterior and posterior vaginal repair to include enterocoele and/or vault prolapse as required	6	616.60	6
# S759	- with anterior or posterior vaginal repair including enterocoele and/or vault prolapse	6	523.55	6
# S710	- with omentectomy for malignancy	6	680.65	6
# S763	- radical (Wertheim or Schauta) - includes node dissection	8	893.55	8
# S762	- radical trachelectomy - excluding node dissection	8	801.10	8

Note:
S757, S758, S759, S710, S763, S762 are total fees. The following codes are not allowed in addition: S722, S760, S812, S813, S738, S741, S745-S747, S780-S782.

		Asst	Surg	Anae
# S776	Staging pelvic node lymphadenectomy for carcinoma (laparoscopic or open)	6	431.20	6
# S781	Para-aortic lymph node dissection (laparoscopic or open) (not to be claimed with Z578 and/or S776)	6	431.20	6

REPAIR

Uterine suspension

		Asst	Surg	Anae
# S771	- any technique - sole procedure	6	248.30	6
# E859	- uterine suspension in conjunction with major procedure	add	47.90	

Hysteroplasty

		Asst	Surg	Anae
# S779	- excision of septum	6	349.00	6
# S775	- unification of double uterus (Strassman)	5	431.45	6
# S777	- uterine inversion, operative	5	349.00	6
# S778	Presacral neurectomy (with or without ovarian neurectomy)	6	349.00	6

FEMALE GENITAL SURGICAL PROCEDURES

FALLOPIAN TUBE

EXCISION, SUTURE OR REPAIR

Ectopic pregnancy

Code	Procedure		Asst	Surg	Anae
# S784	- management by any surgical technique		6	306.85	6
# E852	- with tuboplasty	add		47.90	
# E860	- diagnostic laparoscopy prior to laparotomy	add		71.90	
# S738	Salpingectomy and salpingo-oophorectomy (uni- or bilateral)		6	306.85	6
# S741	Tubal occlusion/interruption/removal by any method or approach for the purpose of sterilization		6	155.70	6

Tubal plastic operation with/without operating microscope (uni- or bilateral)

Code	Procedure	Asst	Surg	Anae
# S735	- fimbriolysis	6	306.85	6
# S736	- salpingostomy	6	359.55	6
# S739	- fimbriolysis and salpingostomy	6	407.45	6

Repair of extensive unilateral or bilateral tubal and peritubal disease

For infertility, pelvic inflammatory disease or endometriosis using operating microscope with or without laser treatment and ureterolysis

Code	Procedure	Asst	Surg	Anae
# S743	- laparotomy	8	616.60	8
# S746	- laparoscopic technique	8	770.75	8

Note:

1. S743, Z737 or E854 claimed for same patient same day as S746 by any surgeon is an insured service payable at nil.
2. Reconstruction or repair for infertility following previous sterilization is not an insured service.

Laparoscopy

Code	Procedure		Asst	Surg	Anae
# Z552	- diagnostic		5	131.45	6
# Z553	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants		5	173.25	6
# E855	- with dye injection	add		25.85	
# E856	- with endometrial	add		25.85	
# E857	- with D&C	add		46.00	
# Z718	Laparoscopy for oocyte retrieval		5	174.50	6
# Z737	Laser treatment of extensive pelvic disease		5	215.80	6

ENDOCRINE SURGICAL PROCEDURES

THYROID GLAND

		Asst	Surg	Anae
	INCISION			
Z726	Aspiration, thyroid cyst		28.60	
# Z727	Percutaneous silicone core needle biopsy		57.50	6
Z771	Aspiration biopsy, thyroid gland or nodule fine needle method		28.60	
# S786	Abscess		82.25	6
	EXCISION			
	Biopsy			
# S787	- surgical	5	213.15	6
	Thyroidectomy			
# S788	- total	6	615.90	8
# S789	- subtotal	6	484.15	7
# S790	- hemi	6	369.80	7
# E880	- parathyroid(s) re-implantation add		184.60	
# E881	- if requiring splitting of sternum add		82.25	
# S791	Excision of solitary nodule	6	303.80	6

ENDOCRINE SURGICAL PROCEDURES

PARATHYROID, THYMUS AND ADRENAL GLANDS

EXCISION

Code	Procedure	Asst	Surg	Anae
# S795	Exploration and/or removal, parathyroids or parathyroid tumour	6	605.45	8
# S796	- if requiring splitting of sternum	10	687.60	13
# E880	- parathyroid(s) re-implantation add		184.60	
# E885	- transcervical thymectomy performed in association with parathyroidectomy add		106.00	
# S792	Re-exploration of neck for hyperparathyroidism	6	687.60	8
# E882	- with hemi thyroidectomy add		177.40	
# E883	- with subtotal thyroidectomy add		266.60	
# E884	- with total thyroidectomy add		374.00	
# S797	Thymectomy	10	615.10	13

Adrenalectomy or exploration

Code	Procedure	Asst	Surg	Anae
# S798	- unilateral	10	430.85	10
# S799	- bilateral, with or without oophorectomy	10	668.45	11

Adrenalectomy

Code	Procedure	Asst	Surg	Anae
# S800	- unilateral for pheochromocytoma	10	581.20	13
# E793	- laparoscopic or laparoscopic assisted, to S798, S799 or S800 add 25%			

Note:

When an adrenalectomy is performed in conjunction with a nephrectomy, and is incidental to the removal of the kidney, there should be no additional claim for the adrenalectomy.

Code	Procedure	Asst	Surg	Anae
# Z772	Thymus transplant		81.45	6

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

			Asst	Surg	Anae
Z811	Intravenous drug test for pain			54.10	6
# E919	- intracranial duroplasty (greater than 2 cm diameter) to any intracranial procedure	add		244.80	
# E381	- intra-operative, diagnostic or physiological neuro monitoring	add		179.30	
# E921	- repeat cranial procedure - payable in addition to any intracranial procedure and N111 but excluding N127	add		215.35	

BRAIN

Craniotomy plus excision

			Asst	Surg	Anae
	Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour				
# N103	- supratentorial		15	1384.75	15
# N151	- infratentorial		15	1598.45	15
# N152	Craniotomy plus lobectomy		15	1451.55	15
# E901	- with operating microscope	add		215.35	
	Meningioma and other tumourous lesions, including pituitary tumours				
# N102	- supratentorial		15	1598.45	15
# N153	- infratentorial or basal		15	2078.10	15
# E901	- with operating microscope	add		215.35	
# E902	- lesion greater than 2 cm diameter, to N102, N153	add		373.80	
# E903	- team fee for acoustic neuroma, same approach	add		614.70	
# N111	Transsphenoidal microscopic approach to the pituitary fossa for hypophysectomy, removal of adenoma or other tumours		15	1598.45	15

INTRACRANIAL ANEURYSM REPAIR

Craniotomy or endovascular approaches

			Asst	Surg	Anae
# N105	Carotid circulation - per vessel		15	1704.50	15
# N154	Vertebrobasilar circulation, including aneurysm of vein of Galen		15	1362.35	15
# E901	- with operating microscope, to N105, N154	add		215.35	
# E898	- lesion greater than 2.5 cm, to N105, N154	add		229.55	
# E979	- clinoidal drilling for complex aneurysms, to N105, N154	add		215.50	

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

			Asst	Surg	Anae
	CEREBRAL ARTERIOVENOUS MALFORMATION				
	Craniotomy for obliteration and/or excision				
# N106	- supratentorial		15	1311.15	15
# N155	- infratentorial		15	1362.35	15
# E895	- of cerebral arteriovenous malformation greater than 4 cm	add		373.80	
# E901	- with operating microscope	add		215.35	
# E908	- removal of intracerebral and/or subdural haematoma in conjunction with a ruptured intracranial aneurysm or arteriovenous malformation, to N105, N106, N154, N155	add		230.55	
# N107	Extracranial approach to include balloon catheter or embolization techniques		15	855.80	15
# N218	Extracranial-intracranial microvascular anastomosis superficial temporal artery		15	1178.35	15
# N156	Occipital artery		15	1229.55	15
# E904	- posterior fossa	add		241.00	
# N121	Extracranial-intracranial long venous bypass (from internal carotid in the neck or any of the trunk vessels in the neck or chest to a major intracerebral vessel, i.e. vertebral, internal carotid, middle cerebral)		15	1711.40	15
	Carotid-cavernous fistula				
# N108	- intracranial obliteration to include combined cervical and intracranial procedure		15	1229.55	15
# N118	- extracranial approach to include balloon catheter or embolization techniques		15	747.60	15
	SPONTANEOUS INTRACEREBRAL HAEMORRHAGE				
	Craniotomy plus removal				
# N104	- supratentorial		15	881.30	15
# N157	- infratentorial		15	988.60	15
# N120	Burr hole plus drainage		15	481.90	15
	INTRACRANIAL CYST				
	Craniotomy plus evacuation				
# N158	- supratentorial		15	881.30	15
# N159	- infratentorial		15	1014.15	15
	Note: N158, N159 to include interventriculostomy				
# N160	Burr hole plus aspiration		15	399.45	15

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
	INTRACRANIAL ABSCESS			
# N117	Craniotomy	15	1385.05	15
# N127	Re-opening of craniotomy for post-operative haematoma or for removal of bone flap	11	450.60	11
# N113	Craniotomy for brain biopsy (other than for tumour)	11	614.70	11
# N130	Craniotomy plus midline commissurotomy	15	1014.85	15
	Burr hole			
# N115	- aspiration	7	533.20	7
# Z818	- subsequent aspiration through existing burr hole within 30 days		215.35	
# Z813	- plus needling of brain for biopsy	7	296.90	7
# N109	Hemispherectomy	15	1878.35	15
# N110	Lobectomy and/or excision of cortical scar for epilepsy	15	2184.20	15
# N128	Repair of encephalocoele	15	798.80	15
# N129	Posterior fossa decompression for Arnold Chiari malformation	15	963.00	15
# E901	- with operating microscope, to N129 add		215.35	
# N126	Intra-oral approach to lesions of the skull base and upper cervical spine	15	1442.95	15
# E381	- intra-operative, diagnostic or physiological neuro monitoring add		179.30	
# N123	Stereotaxis - intracranial (to include ventriculography)	11	1076.75	11
# E931	- with implantation (and removal) of radioactive sources into brain tumour add		222.85	

Functional Stereotaxy

Payable for neuroablative and implantation therapy for treatment of movement disorders of basal ganglia and connections (e.g. Parkinson's disease). Must include pre-operative planning, application of stereotactic frame, intraoperative imaging, micro-electrode placement and recording, ablation of lesion and/or electrode implantation.

# N124	Functional stereotaxy	9	1551.20	11

Note:
N123 performed in conjunction with N124 is an insured service payable at nil.

# E896	- sophisticated micro-electrode recording during stereotaxis (not billable in conjunction with E381) add		400.40	
# N119	Intracranial implantation of chronic surface electrodes	11	901.25	11
# Z823	Implantation or revision of stimulation pack or leads (peripheral nerve, brain)		307.40	
# Z824	Removal of chronic surface or depth electrodes		266.60	
# Z802	Ventricular puncture through previous burr hole or fontanelle or puncture and/or aspiration of cisterna		81.65	7

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

INTRACRANIAL ABSCESS

Ventriculoscopy

		Asst	Surg	Anae
# Z825	- to include burr hole		317.85	7
# E916	- with biopsy . . . add		132.80	
# E917	- with interventriculostomy . . . add		132.80	
# E918	- with removal of foreign body . . . add		132.80	
# Z819	External ventricular drainage	nil	215.35	6
# Z820	Insertion of intracranial catheter or transducer for purposes of monitoring	nil	317.85	6
# Z812	Subsequent revisions or replacements within 30 days. . . . each	5	215.35	6

CRANIO-CEREBRAL INJURIES

		Asst	Surg	Anae
UVC	Non-operative care		visit. fee	

Reduction of skull fracture

		Asst	Surg	Anae
# N139	- simple, depressed	7	373.80	7
# N140	- compound	11	507.55	11
# E912	- with repair of dural laceration . . . add		132.80	6

Extracerebral haematoma and/or hygroma

		Asst	Surg	Anae
# N143	Drainage by burr hole(s) - unilateral	7	507.55	7
# N144	Drainage and/or removal by craniotomy	11	798.80	11

Note:

The Medical Consultant will be requested to give professional assessment to claims with multiple procedures e.g. N144, N148.

CEREBRAL INJURY

		Asst	Surg	Anae
# N148	Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture)	15	881.30	15
# N149	Removal of foreign body from brain	15	881.30	15
# N150	C.S.F. leak - intracranial repair (to include trans-sphenoidal approach)	15	1065.45	15
# N200	Decompressive craniectomy (frontal, sub-temporal)	11	614.70	11

Subdural tap(s)

		Asst	Surg	Anae
# Z803	- unilateral		53.10	

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

CRANIAL NERVES

Code	Procedure	Asst	Surg	Anae
# N258	Percutaneous coagulation or glyceral injection of gasserian (trigeminal) ganglion or root - unilateral	nil	409.85	11
# N259	V - Decompression or rhizotomy (partial or complete) trigeminal nerve	11	481.90	11
# N265	VII - Differential section facial nerve for hemi-facial spasm (extracranial approach)	6	348.30	6
# N266	Anastomosis hypoglossal or accessory to facial nerve	6	563.50	6
# N267	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves	11	963.00	11
# E901	- with operating microscope, to N266, N267 add		215.35	
# N269	XI - Division of nerves to sternomastoid in neck	6	292.25	6
# Z826	Inferior dental neurectomy	5	184.00	6
# Z827	Infraorbital or supraorbital neurectomy	5	158.45	6

CAROTID AND VERTEBRAL ARTERIES

Code	Procedure	Asst	Surg	Anae
# N220	Carotid endarterectomy (with or without bypass and/or patch graft)	10	764.20	10
# N223	Vertebral endarterectomy	10	798.80	10
# Z815	Temporal artery - biopsy, ligation or cryosurgery		107.20	6
# Z808	Progressive carotid occlusion by Selverstone clamp	10	317.85	10
# Z807	Removal of Selverstone clamp	10	266.60	10
# E381	- intra-operative diagnostic or physiological neuro monitoring, to N220, Z808 add		179.30	

CSF SHUNTING PROCEDURES

Code	Procedure	Asst	Surg	Anae
# N230	CSF shunting procedures - all types	11	474.45	11
	Revision of CSF shunt			
# N245	- operative - all types	7	281.70	7
# Z801	- non-operative		40.80	
	Conversion of shunt (e.g. ventriculoperitoneal to ventriculoatrial)			
# N174	- includes removal of existing shunt	7	420.30	7
# N246	Removal of shunt - any type	7	184.00	7
# Z809	Insertion of CSF reservoir (Ommaya) including burr holes	11	241.00	11
# N249	Third ventriculostomy	11	655.60	11
# Z821	Injection of diagnostic or therapeutic agent into shunt apparatus		53.10	

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

SKULL

Repair of skull defect

		Asst	Surg	Anae
# N161	Acrylic or metal cranioplasty	11	563.50	11
# N201	Rib graft cranioplasty (defect less than 7.5 cm)	15	855.80	15
# N202	Replacement of bone flap	11	481.90	11
# N203	Skull tumour, excision	11	373.80	11

Craniosynostosis, linear craniectomy

		Asst	Surg	Anae
# N206	- one suture	11	430.75	11
# N207	- multiple sutures	15	563.50	15

Morcellation procedure

		Asst	Surg	Anae
# N162	- one suture	11	430.75	11
# N163	- multiple sutures	15	614.70	15

Lateral canthal advancement

		Asst	Surg	Anae
	Unilateral			
# N164	- one surgeon	15	696.35	15
# N165	- two surgeons, major portion	15	430.75	15
# N166	- two surgeons, lesser portion		345.35	
	Bilateral			
# N167	- one surgeon	15	952.55	15
# N168	- two surgeons, major portion	15	614.70	15
# N169	- two surgeons, lesser portion		461.10	

Craniotomy

		Asst	Surg	Anae
# N208	- for craniofacial repair	15	918.15	15
# E922	- with repair of frontonasal encephalocele add		215.35	

ORBIT

Craniotomy

		Asst	Surg	Anae
# N211	- plus removal of orbital tumour	15	1116.60	15
# N212	- plus orbital decompression (roof of orbit with or without lateral wall)	15	1045.45	15
# N213	- for decompression of optic nerve(s)	15	1116.60	15
# E901	- with operating microscope, to N211, N213 add		215.35	

NEUROLOGICAL SURGICAL PROCEDURES

PERIPHERAL NERVES

		Asst	Surg	Anae
# E906	- to basic fee for neurolysis, tumour excision, nerve suture or graft when using operating microscope ... add 40%			
# E381	- intra-operative, diagnostic or physiological neuro monitoring ... add		179.30	
# E925	- to basic fee for a repeat peripheral nerve procedure, (e.g. repair, transposition, graft or tumour excision) when repair delayed for more than 4 weeks ... add 30%			

Exploration, decompression, division, excision, biopsy, neurolysis and/or transposition

		Asst	Surg	Anae
# N188	- minor nerve - including digital, cutaneous or lateral femoral cutaneous nerve	5	153.70	6
# N285	- major nerve - excluding carpal tunnel or ulnar nerve at elbow	5	256.15	6

Note:
N188 or N285 when performed through the same incision as flexor tendon repairs R585 or E581 is an insured service payable at nil.

		Asst	Surg	Anae
# N282	Brachial plexus (excluding thoracic outlet syndrome or cervical rib)	6	593.85	6
# N177	Sciatic nerve in buttock	6	430.75	6
# N286	Tumour or neuroma - major nerve	5	317.85	6

Nerve suture

		Asst	Surg	Anae
# N289	- minor - (sensory/cutaneous nerve)	5	184.00	6
# N287	- major - (mixed sensory and motor nerve, or pure motor nerve)	5	430.75	6

Nerve graft

		Asst	Surg	Anae
# N183	- minor - (sensory/cutaneous nerve)	5	307.40	6
# N288	- major - (mixed sensory and motor nerve, or pure motor nerve)	5	614.70	6
# E899	- for each additional cable, to N288 ... add		102.45	

Note:
Nerve graft fees include harvesting of the nerve(s) required for grafting.

		Asst	Surg	Anae
# Z816	Implantation of electrode for peripheral nerve stimulation	5	241.00	6
# Z823	Implantation or revision of stimulation pack or leads, (peripheral nerve, brain)	6	307.40	8
# N290	Carpal tunnel release	5	156.50	6
# N190	Exploration and/or decompression and/or neurolysis of ulnar nerve (elbow)	5	215.35	6
# N189	Ulnar nerve transposition at elbow - may include exploration, decompression and/or neurolysis	5	279.25	6
# N283	Decompression, exploration for thoracic outlet syndrome including excision of cervical and/or first rib and to include scalenotomy	6	389.05	6
# N295	Excision of Morton's or subcutaneous neuroma, glomus or small cutaneous nerve tumour	5	109.95	6
# E911	- implantation of neuroma into bone or muscle, to N286, N295 ... add 40%			

NEUROLOGICAL SURGICAL PROCEDURES

NOT ALLOCATED

OCULAR AND AURAL SURGICAL PROCEDURES

EYEBALL

EXAMINATION

		Asst	Surg	Anae
# Z850	- when sole procedure or with unlisted minor procedures with general anaesthesia		95.15	6
E982	- when service is rendered to newborn, infant or child (ages 0 to 15 inclusive), to Z850 add 30%			

EXCISION

		Asst	Surg	Anae
# E108	Enucleation, donor eye, post-mortem (one or both)		131.25	

REPAIR

		Asst	Surg	Anae
# E104	Removal of intraocular foreign body	5	415.85	6
# E105	Non-magnetic - posterior segment	5	424.35	6

Penetrating wound

		Asst	Surg	Anae
# E106	- with prolapse of intraocular tissue	5	308.30	6
# E107	- without prolapse of intraocular tissue	5	246.55	6

OCULAR AND AURAL SURGICAL PROCEDURES

CORNEA

			Asst	Surg	Anae
	INCISION				
# Z851	Paracentesis			52.40	6
	Removal embedded foreign body				
	- local anaesthetic				
Z847	- one foreign body			26.60	
Z848	- two foreign bodies			38.00	
Z845	- three or more foreign bodies (see General Preamble GP12)			I.C	
# Z852	- general anaesthetic			74.20	6
	Chelation of band keratopathy with EDTA				
Z849	- local anaesthetic			26.60	
# Z863	- general anaesthetic			74.20	6
# E128	Anterior chamber - open evacuation of clot		5	369.25	6
	EXCISION				
	Pterygium				
# E206	- simple (unilateral)			138.90	6
# E205	- with partial keratectomy		5	308.30	6
# E207	- with lamellar graft		5	453.00	8
# E937	- with autogenous conjunctival transplant	add		80.90	
# E948	- with mucous membrane graft	add		113.20	
# E117	Keratectomy or relaxing incisions post penetrating keratoplasty or post traumatic corneal scar (non cosmetic)		5	308.30	6
	Excision of dermoid				
# E118	- with partial keratectomy			308.30	6
# E119	- with lamellar graft		5	453.00	8
	Ulcer cautery				
	Including laser and/or electrocautery, epithelial debridement, cryotherapy, corneal biopsy and/or corneal puncture				
Z871	- local anaesthetic			26.60	
# Z853	- general anaesthetic			74.20	6
	REPLACEMENT				
	Corneal transplant				
# E121	- penetrating		5	575.85	8
# E951	- with artificial prosthesis	add		52.40	
# E122	- lamellar		5	453.00	8
# E123	Division of iris to cornea			161.75	6

OCULAR AND AURAL SURGICAL PROCEDURES

SCLERA, IRIS AND CILIARY BODY

SCLERA

		Asst	Surg	Anae
# E127	Sclerotomy, posterior		166.45	6

IRIS AND CILIARY BODY

		Asst	Surg	Anae
# E131	Laser iridotomy	5	161.75	6
# E134	Laser angle surgery		205.55	6
# E130	Iridectomy - surgical - when sole procedure	5	308.30	6
# E132	Glaucoma filtering procedures	5	370.20	6
# E983	- following previous glaucoma filtering procedure, to E132 . . . add 25%			
# E136	- with intraocular implant of seton, to E132 . . . add 15%			
# E133	Extraocular glaucoma procedures	5	182.75	6
# E135	Ciliary body re-attachment	5	505.45	8

OCULAR AND AURAL SURGICAL PROCEDURES

CRYSTALLINE LENS

		Asst	Surg	Anae
	INCISION			
# E137	Needling (discission) - primary or subsequent	5	161.75	6
# E139	Capsulotomy	5	161.75	6
	EXCISION			
	Cataract			
	To include retrobulbar injection when administered by surgeon			
# E140	- all types of, by any procedure		413.60	6
# E141	- dislocated lens extraction	5	505.45	6
# E950	- insertion of intraocular lens, add		102.75	
# E143	Excision of secondary membrane with corneal section following cataract extraction	5	262.70	6
# E138	Fixation of intraocular lens (McCannell suture procedure)	5	267.35	6
# E144	Removal of intraocular lens	5	314.05	6
# E145	Repositioning surgical of dislocated intraocular lens		161.75	6
# E146	Insertion of secondary intraocular lens	5	308.30	8

OCULAR AND AURAL SURGICAL PROCEDURES

VITREOUS

			Asst	Surg	Anae
	Anterior vitrectomy				
# E940	- when done in conjunction with another intraocular procedure	add		89.45	
# E148	Vitrectomy by infusion suction cutter technique		5	699.50	8
# E938	- with transscleral retinal suturing	add		213.20	
# E149	Vitreous injection or aspiration, posterior with needle for culture and/or injection of medication		5	181.75	6
# E142	Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation		5	782.35	8
	Vitreous exchange (air, gas or artificial vitreous substance)				
# E936	- to vitrectomy	add		60.90	

OCULAR AND AURAL SURGICAL PROCEDURES

EXTRA OCULAR MUSCLES

RETINA

		Asst	Surg	Anae
# E151	Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as an initial procedure	6	282.65	6
# E152	Scleral resection or buckling procedure - with or without diathermy, photo-coagulation or cryopexy, primary or subsequent procedure	6	658.55	6
# E153	Secondary operation following unsuccessful operation or fresh detachment in the same eye by a different surgeon with or without diathermy, photocoagulation or cryopexy	6	761.35	6
# E161	Removal of scleral implant		185.60	6
# E154	Photocoagulation (xenon, argon laser, etc.) - one eye		182.75	6
# E155	Cryopexy - extraocular or sub-conjunctival - one eye		182.75	6

REPAIR

Strabismus procedures

		Asst	Surg	Anae
# E159	- one muscle, one or both eyes	5	315.25	6
# E158	- two muscles, one or both eyes	5	444.25	6
# E162	- three or more muscles, one or both eyes	5	514.05	6
# E949	- for adjustable suture add		81.85	
# E952	- repeat strabismus procedure add		123.70	

OCULAR AND AURAL SURGICAL PROCEDURES

ORBIT

		Asst	Surg	Anae
	INCISION			
# E164	Drainage of abscess		197.90	6
	EXCISION			
# E102	Enucleation, with or without primary implant	5	262.70	6
# E103	Evisceration, with or without primary implant	5	262.80	6
# E109	Enucleation/evisceration with insertion of implant and reattachment of extraocular muscles	5	328.40	6

Note:
E102 or E103 are not eligible for payment with E109.

		Asst	Surg	Anae
# E171	Exenteration	5	296.90	6
# E941	- with major plastic repair add		296.90	
# E181	Secondary orbital implant	5	372.05	6
	Tumour or foreign body			
# E166	- anterior route	5	308.30	6
# E167	- posterior exposure	5	514.80	6
# E172	Biopsy (anterior)		161.75	6
# E168	Biopsy (posterior exposure)		308.30	6
# E165	Lateral orbitotomy (Kronlein)	5	424.35	6
	Decompression			
# E169	- two walls	5	494.00	6
# E170	- three walls	5	575.85	6
	RECONSTRUCTION			
	Dermis fat graft			
# E160	- immediately following enucleation		190.30	
# E163	- delayed	5	514.80	6
# E176	Fornix reconstruction		246.55	6
# E177	- with mucous membrane graft		321.60	6
# E937	- with autogenous conjunctival transplant add		80.90	
	Free mucous membrane graft			
# E178	- full thickness		222.65	6
# E179	- split thickness		296.90	6
# E180	Alloplastic volume replacement		411.20	6

Note:
Repair - for E173 and E174 see Skull and Mandible - Musculoskeletal System.

OCULAR AND AURAL SURGICAL PROCEDURES

EYELIDS

		Asst	Surg	Anae
	INCISION			
	Drainage of abscess			
Z854	- local anaesthetic		40.90	
# Z855	- general anaesthetic		81.85	6
	EXCISION			
	Chalazion			
	Single or multiple			
Z874	- local anaesthetic		40.90	
E542	- when performed outside hospital add		11.15	
# Z856	- general anaesthetic		81.85	6
	Note: See Appendix D Surface Pathology.			
	Epilation			
Z857	- by hyfrecator, electrolysis		26.60	6
Z858	- by cryopexy		65.70	6
	Note: Verruca, keratosis, etc. - see Skin and Subcutaneous Tissue - Integumentary System also Lid Tumours or Unlisted Plastic Procedures.			
	SUTURE			
# E190	Tarsorrhaphy		111.40	6
# E191	Double adhesion		161.75	6
	REPAIR			
# E192	Ptosis	5	313.15	6
# E193	- repeat or second repair	5	393.00	6
# E194	Distichiasis - unilateral	5	241.70	6
# E195	Trichiasis, repair by tarsal transplantation	5	241.70	6
# E196	Entropion, other than Zeigler puncture	5	262.70	6
# E945	- repeat by second surgeon add		52.40	
# E948	- with mucous membrane graft add		113.20	
# E197	Ectropion, other than Zeigler puncture	5	262.70	6
# E945	- repeat by second surgeon add		52.40	
Z860	Zeigler punctures (for entropion/ectropion)		26.60	6
	Note: With skin graft - see Plastic Surgery Procedures - Integumentary System.			
# E199	Laceration, full thickness		131.25	6
# E198	- including lid margin		262.70	6

OCULAR AND AURAL SURGICAL PROCEDURES

EYELIDS

		Asst	Surg	Anae
# E221	Laceration of eyelid including levator palpebrae superioris with ptosis	5	329.30	6
	Blepharoplasty			
# E200	- excision of skin, with or without partial excision of the orbicularis oculi muscle - one lid		82.80	6
# E201	- same as E200 plus removal of orbital fat and/or major lid fold reconstruction - one lid	5	205.55	6
	Note: Blepharoplasty is only insured in those circumstances described in the Appendix D - prior approval of the Ministry of Health and Long-Term Care is required.			
# E211	Lid lengthening procedure	5	288.35	6
# E953	- with scleral graft add		80.90	
# E222	Primary closure of full thickness lid defect	5	267.35	6
# E942	- with cantholysis add		53.20	
# E943	- with releasing rotation flap including cantholysis add		89.45	
# E223	Tarsoconjunctival flap and skin graft (Hughes)	5	484.35	6
# E224	- second stage		108.45	6
# E225	Lower or upper eyelid bridge flap	5	484.35	6
# E226	- second stage		108.45	6
# E227	Temporal rotation flap	5	514.80	6
# E944	- with free posterior lamellar graft add		175.15	
# E228	Free tarsal, scleral or cartilage graft with local skin mobilization	6	535.80	8
# E229	Free composite eyelid graft	6	535.80	8
# E230	Medial canthoplasty (skin and muscle)	5	257.90	6
	Medial canthal tendon			
# E231	- tendon repair only	5	267.35	6
# E232	- fixation to bone	5	412.05	6
# E233	- when done in conjunction with another procedure add		153.25	
	Lateral canthal surgery			
# E234	- canthotomy (not to be claimed with E140, E141)		51.45	6
# E977	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees add 25%			
	Note: E977 is payable only in addition to codes E222, E223, E225, E226, E227, E228, E229 or E300.			
# E235	Cantholysis - when primary procedure		107.50	6
# E236	Lateral canthopexy		203.70	6
# E930	- when done in conjunction with another procedure add		102.35	
UVC	Removal of foreign body		visit fee	

OCULAR AND AURAL SURGICAL PROCEDURES

CONJUNCTIVA

EXCISION

		Asst	Surg	Anae
# E208	Peritomy (Gunderson conjunctival flap)		111.40	6
Z861	Biopsy		26.60	6

REPAIR

		Asst	Surg	Anae
# E210	Excision of conjunctival lesion		80.90	6
# E948	- with mucous membrane graft ... add		113.20	
E937	- with autogenous conjunctival transplant ... add		80.90	

OCULAR AND AURAL SURGICAL PROCEDURES

LACRIMAL TRACT

		Asst	Surg	Anae
	INCISION			
# Z862	Dacryocystotomy - general anaesthetic		52.40	6
# Z917	Three "Snip" punctum procedure - per punctum - maximum 4 per patient . . . each		65.70	6
	EXCISION			
# E215	Dacryocystectomy	5	262.70	6
	REPAIR			
	Lacerated canaliculus			
# E216	- immediate repair	5	212.15	6
# E217	- delayed repair	5	411.20	6
# E218	Dacryocystorhinostomy	5	424.35	6
# E939	- repeat procedure by second surgeon . . . add		87.55	
# E954	- with lacrimal bypass procedure (e.g. Lester Jones) or canalicular reconstruction . . . add		80.90	
	Lacrimal bypass procedure (e.g. Lester Jones)			
# E219	- when sole procedure (both stages)		181.75	6
	MANIPULATION			
Z901	Irrigation of nasolacrimal system - unilateral or bilateral		21.00	
	Probing and dilation of duct, initial or repeat			
	Local anaesthetic			
Z902	- unilateral		21.00	
	General anaesthetic			
# Z864	- unilateral or bilateral		80.90	6
# Z865	- with insertion of inlying tube or filament		160.85	6
Z918	Re-insertion of Lester Jones tube		52.40	

OCULAR AND AURAL SURGICAL PROCEDURES

EXTERNAL EAR

PREAMBLE

When debridement of ears under microscopy is carried out for access purposes only, no claim should be made for the debridement.

		Asst	Surg	Anae
	ENDOSCOPY			
	Removal of foreign body			
Z915	- simple		10.55	
Z866	- complicated, general anaesthetic		50.90	6
# E302	- requiring post auricular or endaural incisions		202.35	6
# E303	- from middle ear space		202.35	6
	Note: Z915 claimed solely for removal of cerumen is payable at nil.			
	Removal of drainage tube(s)			
# Z906	- general anaesthetic		35.50	6
	INCISION			
Z909	Biopsy, ear canal		25.85	
# Z846	- general anaesthetic (if sole procedure performed)		50.90	6
	Incision and drainage of extensive haematoma of pinna with packing of ear and external compression dressing			
# E317	- general anaesthetic		139.95	6
# E318	- local anaesthetic		92.40	
# E305	Limited incision for perichondritis, removal of cartilage and drainage		155.30	6
# E306	Radical surgery for perichondritis		291.50	6
	EXCISION			
	Local excision, polyp			
Z904	- office		25.85	
# Z905	- hospital		50.90	6
	Resection of pinna			
# E300	- with primary closure		172.65	6
# E977	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees, to E300 ... add 25%			
# E301	- with local flap		247.35	6
	Exostosis			
# E311	- simple endomeatal surgery and removal and drilling out of exostosis		197.45	6
# E312	- with multiple removal with necessary grafting		247.35	6
# E313	- post auricular approach		297.25	6
# Z903	Pre-auricular sinus		33.60	
# E309	- general anaesthetic		208.05	6

REPAIR

Congenital defects

			Asst	Surg	Anae
	External				
# E307	- minor		5	219.60	6
# E308	- major		5	345.15	6
# E310	Otoplasty for correction of outstanding ears - unilateral		5	233.00	6
# E304	Reconstruction of total ear with cartilage graft (e.g. Brent Technique), first stage		5	619.35	9

Note:

1. E304, E307, E308 - Descriptive details of procedure (e.g. operative report) should be submitted with claims for professional assessment (see Surgical Preamble, paragraph 18).
2. E310 - for patients 18 years of age or older, please see Appendix D, Sub-Surface Pathology.

			Asst	Surg	Anae
# E314	Meatoplasty or canalplasty for congenital malformation		5	297.25	6
# E955	- with grafting of canal	add		202.35	1
# E956	- with tympanoplasty and/or ossiculoplasty, and/or mastoidectomy	add		399.90	2

OCULAR AND AURAL SURGICAL PROCEDURES

MIDDLE EAR

INTRODUCTION

Under microscopy, debridement of mastoid cavities, and/or ears with significant external or middle ear pathology and/or repair of small perforation but not for removal of cerumen.

		Asst	Surg	Anae
Z907	- unilateral or bilateral		26.85	
# Z908	- under general anaesthetic - when sole ear procedure performed		50.90	6

Note:
Debridement not performed under microscopy (e.g. if performed using loupes or magnifying headlights) or in the absence of significant external or middle ear pathology, or for removal of cerumen must be claimed under G420.

INCISION

		Asst	Surg	Anae
# Z912	Myringotomy, to include aspiration when indicated - unilateral		42.15	6
# Z914	- with insertion of ventilation tube using operating microscope - unilateral		78.60	6

EXCISION

Mastoidectomy

		Asst	Surg	Anae
# E320	Cortical mastoidectomy	5	345.15	6
# E322	Modified or radical mastoidectomy	5	514.70	7
# E315	Revision mastoidectomy with revision of middle ear	5	553.20	7
# E946	- with mastoid cavity obliteration (E320, E322 or E315) add		106.45	
# E959	- with meatoplasty and/or canalplasty add		106.45	
# E960	- with ossiculoplasty (E320, E322 or E315) add		85.30	

REPAIR

		Asst	Surg	Anae
# E323	Myringoplasty		209.05	6

Tympanoplasty

		Asst	Surg	Anae
# E336	Type 1 (myringoplasty with exploration of middle ear)		345.15	7
# E337	- with ossiculoplasty		468.85	7
# E957	- with mastoidectomy add		138.05	
# E959	- with meatoplasty and/or canalplasty add		106.45	
# E333	Ossiculoplasty	5	406.55	7
# E325	Facial nerve decompression	5	642.45	9
# E326	Facial nerve grafting (to include decompression)	5	987.65	9
# E327	Closure of mastoid fistula	5	252.15	6
# E328	Tympanotomy		236.80	6
# E981	- with removal of middle ear tumour add		92.10	2
# E329	Tympanic neurectomy		370.10	6
# E316	Tympanotomy with fistula repair		395.05	6
# E350	Donor homograft - tympanic membrane, malleus and incus in continuity - unilateral		136.15	

SPINAL SURGICAL PROCEDURES

FRACTURES OF THE SPINE

			Asst	Surg	Anae
# F200	No reduction, brace (includes Halo orthosis), total care by operating surgeon			178.50	
# F201	Closed reduction, fracture/dislocation (Halo or caliper traction)		5	280.50	6
# E383	- acute spinal cord injury premium, to F201	add		255.00	
# N572	Open reduction, any single level, spine fracture/dislocation, anterior/posterior		8	1020.00	11
# E395	- open reduction, additional level, spine fracture/ dislocation, anterior/posterior, to N572	add		306.00	
# E383	- acute spinal cord injury premium, to N572	add		255.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N572	add		179.30	
# E362	- combined thoracotomy/laparotomy, to N572	add		153.00	
# E378	- 3D stereotactic spinal procedure, to N572	add		1020.00	
# E379	- 2D stereotactic spinal procedure, to N572	add		510.00	
# N573	Anterior odontoid screw fixation		8	1020.00	11
# E378	- 3D stereotactic spinal procedure, to N573	add		1020.00	
# E379	- 2D stereotactic spinal procedure, to N573	add		510.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N573	add		179.30	
# N570	Vertebroplasty (injection of bone cement) as sole procedure, first level		7	459.00	9
# E388	- vertebroplasty combined with any other procedure, first level, to other procedure	add		204.00	
# E391	- vertebroplasty, each additional level, to N570 or E388	add		204.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N570 or E388	add		179.30	
# N583	Kyphoplasty (balloon tamp and injection of bone cement) as sole procedure, first level		8	969.00	11
# E392	- kyphoplasty combined with any other procedure, first level, to other procedure	add		510.00	
# E393	- kyphoplasty, each additional level, to N583 or E392	add		510.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N583 or E392	add		179.30	

Note:

1. Decompressive services at the level of the fracture are not eligible for payment when rendered with N572 as they are included in the open reduction.
2. No other services in the Spinal Surgical Procedures section are eligible for payment when rendered with N573 except E378, E379 or E381.
3. No other services in the Spinal Surgical Procedures section are eligible for payment when rendered with N570 except E391 or E381.
4. No other services in the Spinal Surgical Procedures section are eligible for payment when rendered with N583 except E393 or E381.

[Commentary:
Fusion procedures are eligible for payment when performed in addition to N572.]

SPINAL SURGICAL PROCEDURES

TUMOURS/INFECTIONS OF THE SPINE

		Asst	Surg	Anae
# E386	- extradural decompression - spinal cord or cauda equina - tumour or infection .... add 40%			

Note:

E386 only applies to the major decompressive procedure.

		Asst	Surg	Anae
# N553	Simple soft tissue tumour excision under 5cm	6	204.00	8
# N554	Radical soft tissue tumour excision 5cm and greater	9	484.50	13

Spinal osteomyelitis

		Asst	Surg	Anae
# N549	- incision and drainage including sequestrectomy, anterior approach	7	632.40	10
# N548	- incision and drainage only, posterior approach	5	102.00	6
# N550	- sequestrectomy, posterior approach	5	357.00	6

Note:

N548 is not eligible for payment when rendered with N550 as it is included in the N550 service.

		Asst	Surg	Anae
# N560	Intradural extramedullary spinal tumour - partial or total removal	8	1530.00	10
# N561	Intradural intramedullary spinal tumour - partial or total removal	9	1734.00	12
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N560 or N561 .... add		179.30	
# E382	- spinal duroplasty using autologous/allogenic/ synthetic tissue, to N560 or N561 .... add		244.80	
# E383	- acute spinal cord injury premium, to N560 or N561 .. add		255.00	

Note:

1. No other decompressive codes are eligible for payment when rendered with N560 or N561.
2. N560 is not eligible for payment when rendered with N561.

SPINAL SURGICAL PROCEDURES

PROCEDURES ON MUSCULOSKELETAL ELEMENTS

		Asst	Surg	Anae
# Z940	Vertebral needle biopsy	5	142.80	
	Open vertebral biopsy			
# N546	- posterior approach - sole procedure	5	244.80	7
# N547	- anterior approach - sole procedure	6	306.00	8
# N551	Excision spinous process - sole procedure	5	229.50	6
# N552	Excision transverse process - sole procedure	6	382.50	8

Note:

N546, N547, N551 or N552 are not eligible for payment when rendered with any other service in the Spinal Surgical Procedures section.

SPINAL SURGICAL PROCEDURES

PROCEDURES INVOLVING NEURAL ELEMENTS

		Asst	Surg	Anae
# Z941	Percutaneous diagnostic stimulation of spinal cord, trigeminal nerve root and / or ganglion	6	331.50	8

Note:
E381 is not eligible for payment with Z941.

		Asst	Surg	Anae
# Z942	Implantation or revision of stimulation pack or leads	6	306.00	8
# Z943	Programming infusion pump or dorsal column stimulator		102.00	
# Z944	Lumbar sub-arachnoid drainage of CSF (chronic)		81.60	
# N527	Percutaneous cordotomy or tractotomy	6	469.20	8
# N529	Medullary spinal trigeminal tractotomy	10	1020.00	15
# E383	- acute spinal cord injury premium, to N529 add		255.00	
# N564	Open myelotomy for lesion - unilateral or bilateral	8	1020.00	10
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N527, N529 or N564 add		179.30	

Note:
No decompressive codes are eligible for payment when rendered with N529 or N564.

		Asst	Surg	Anae
# N523	AV malformation of cord - excision/obliteration	10	1530.00	13
# E383	- acute spinal cord injury premium, to N523 add		255.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N523 add		179.30	

Note:
No other decompressive codes are eligible for payment when rendered with N523.

		Asst	Surg	Anae
# N555	Insertion / revision of implantable infusion pump		510.00	8
# N530	Implantation of spinal cord stimulating electrode by laminectomy	8	816.00	10

Note:
N530 is not eligible for payment when rendered with any decompressive codes.

		Asst	Surg	Anae
# N563	Implantation of permanent subcutaneous reservoir including laminectomy	11	510.00	11

Note:
N563 is not eligible for payment when rendered with any decompressive codes.

		Asst	Surg	Anae
# N531	Removal of any stimulation pack or electrode	6	306.00	6

Note:
N531 is not eligible for payment when rendered with any other services in the Spinal Surgical Procedures section.

Percutaneous vertebral facet denervation

		Asst	Surg	Anae
# N556	- one level (uni/bilateral)		142.80	6
# E396	- each additional level (uni/bilateral), to N556 add		71.40	
# N534	Percutaneous radio frequency posterior rhizotomy - any number of levels		306.00	8

APPENDIX H

ASSISTING AT SURGERY AND ANAESTHESIA TIME UNITS TABLE

Time in Minutes [Hours]		Assistant Time Units for Billing	Anaesthesia Time Units for Billing
0-15		1	1
>15-30		2	2
>30-45		3	3
>45-60		4	4
>60-75	[>1h – 1h 15m]	6	6
>75-90	[>1h 15m – 1h 30m]	8	8
>90-105	[>1h 30m – 1h 45m]	10	10
>105-120	[>1h 45m – 2h]	12	12
>120-135	[>2h – 2h 15m]	14	**15**
>135-150	[>2h 15m – 2h 30m]	16	**18**
>150-165	[>2h 30m – 2h 45m]	18	**21**
>165-180	[>2h 45m – 3h]	20	**24**
>180-195	[>3h – 3h 15m]	22	**27**
>195-210	[>3h 15m – 3h 30m]	24	**30**
>210-225	[>3h 30m – 3h 45m]	26	**33**
>225-240	[>3h 45m – 4h]	28	**36**
>240-255	[>4h – 4h 15m]	30	**39**

APPENDIX H

ASSISTING AT SURGERY AND ANAESTHESIA TIME UNITS TABLE

Time in Minutes [Hours]		Assistant Time Units for Billing	Anaesthesia Time Units for Billing
>255-270	[>4h 15m – 4h]	32	42
>270-285	[>4h 30m – 4h 45m]	34	45
>285-300	[>4h 45m – 5h]	36	48
>300-315	[>5h – 5h 15m]	38	51
>315-330	[>5h 15m – 5h 30m]	40	54
>330-345	[>5h 30m – 5h 45m]	42	57
>345-360	[>5h 45m – 6h]	44	60
>360-375	[>6h – 6h 15m]	46	63
>375-390	[>6h 15m – 6h 30m]	48	66
>390-405	[>6h 30m – 6h 45m]	50	69
>405-420	[>6h 45m – 7h]	52	72
>420-435	[>7h – 7h 15m]	54	75
>435-450	[>7h 15m – 7h 30m]	56	78
>450-465	[>7h 30m – 7h 45m]	58	81
>465-480	[>7h 45m – 8h]	60	84
>480-495	[>8h – 8h 15m]	62	87
>495-510	[>8h 15m – 8h 30m]	64	90

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A014	30.10						A25
A015	103.85						A25
A016	50.75						A25
A023	38.70						A31
A024	20.40						A31
A025	59.15						A31
A026	44.45						A31
A033	41.20						A35
A034	22.45						A35
A035	81.60						A35
A036	46.30						A35
A043	51.45						A49
A044	26.50						A49
A045	102.00						A49
A046	51.45						A49
A055	75.35						A30
A063	39.70						A56
A064	22.45						A56
A065	66.30						A56
A066	45.85						A56
A071	53.15						A40
A073	58.25						A40
A074	45.90						A40
A075	142.80						A40
A076	75.35						A40
A078	30.10						A40
A083	39.70						A66
A084	22.45						A66
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A086	45.85						A66
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A184	45.90						A47
A185	127.50						A47
A186	75.35						A47
A188	30.10						A47
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A194	30.10						A67
A195	153.00						A67
A196	75.35						A67
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A203	40.25						A52
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A205	81.60						A52
A206	45.85						A52
A215	46.20						A25
A221	30.10						A38
A225	142.80						A38
A226	75.35						A38
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A244	22.45						A58
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A264	45.90						A59

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A286	64.70						A46
A310	45.90						A63
A311	53.15						A63
A313	58.25						A63
A315	142.80						A63
A316	75.35						A63
A318	30.10						A63
A325	75.35						A38
A331	17.75						A71
A335	30.25						A71
A338	17.75						A71
A340	45.90						A73
A341	53.15						A73
A343	58.25						A73
A345	127.50						A73
A346	75.35						A73
A348	30.10						A73
A353	39.70						A76
A354	22.45						A76
A355	66.30						A76
A356	45.85						A76
A375	75.35						A40
A385	75.35						A47
A395	75.35						A67
A405	58.25						A30
A411	53.15						A34
A413	58.25						A34
A414	45.90						A34
A415	127.50						A34
A416	75.35						A34
A418	30.10						A34
A435	75.35						A44
A471	53.15						A74
A473	58.25						A74
A474	45.90						A74
A475	127.50						A74
A476	75.35						A74
A478	30.10						A74

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A484	45.90						A75
A485	127.50						A75
A486	75.35						A75
A488	30.10						A75
A515	75.35						A63
A525	75.35						A29
A545	75.35						A34
A565	75.35						A59
A575	75.35						A74
A585	64.70						A46
A586	64.70						A46
A595	75.35						A75
A601	53.15						A27
A603	58.25						A27
A604	45.90						A27
A605	127.50						A27
A606	75.35						A27
A608	30.10						A27
A611	53.15						A43
A613	58.25						A43
A614	45.90						A43
A615	127.50						A43
A616	75.35						A43
A618	30.10						A43
A621	53.15						A29
A623	58.25						A29
A624	45.90						A29
A625	127.50						A29
A626	75.35						A29
A628	30.10						A29
A635	65.70						A50
A636	45.10						A50
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A543	41.20						A37
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A645	81.60						A37
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A661	53.15						A59
A665	68.15						A59
A667	255.00						A59

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A775	183.60						A40
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A795	183.60						A67
A813	81.60						A6
A815	127.50						A6
A835	127.50						A50
A888	28.55						A1
A895	178.50						A67
A901	41.75						A2
A902	41.75						A2
A903	61.00						A2
A905	44.65						A1
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A921	31.45						K4
A933	79.20						A2
A935	127.50						A28, A35, A37, A49, A52, A54, A56, A58, A66, A76
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C667	255.00						A61
C675	75.35						A27
C695	255.00						A68
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C771	17.75						A7
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C795	183.60						A68
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C995	27.30						GP49
C996	81.85						GP49
C997	40.95						GP49
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C999B	81.85						GP54
C999C	81.85						GP57

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D008	241.30						N11
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D023	231.10						N21
D025	134.55						N21
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D033	147.60						N52
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D061	193.00						N35
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J863		102.50			44.80		B12
J864		99.85			51.85		B11
J865		192.75			57.05		B11
J866		44.60			26.70		B4, B11
J867		58.75			26.70		B4
J868		462.85			54.70		B5
J869		569.60			47.30		B5
J870		15.05			9.95		B5
J871		105.75			35.20		B5
J872		246.75			50.50		B5
J873		141.25			18.30		B6
J874		63.50			9.75		B6
J875		259.60			39.80		B6
J876		58.15			40.65		B6
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J882		87.00			43.70		B8
J883		373.65			55.85		B8
J884		329.00			43.70		B8
J885		316.10			53.30		B10
J886		90.80			50.65		B10
J887		110.45			42.45		B10
J889		380.25			128.30		J63
J890		380.25			128.30		J63
J891		237.80			93.40		J63
J893		70.70			52.50	00.00	J63
J894		70.70			52.50	00.00	J63

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K029	51.70						A20
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K032	51.70						A22
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K041	31.45						A13
K044	51.70						A39
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K051	80.00						AF1
K052	20.00						AF1
K053	15.00						AF2
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L819	13.60						J38
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L822	74.00						J38
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